FOR OFFICE USE ONLY

APPLICATION RECEIVED: _____

WDACS NEW FREEDOM PROGRAM APPLICATION

Complete and return this application, along with copies of government issued ID to:

Workforce Development, Aging, and Community Services
3333 Wilshire Boulevard, Suite 400
Los Angeles, CA 90010
Attn: WDACS New Freedom Programs

Or e-mail documents to newfreedom@wdacs.lacounty.gov with subject line "WDACS New Freedom Application."
Or submit an online application at http://newfreedom.lacounty.gov
Please note that in some cases applicants may be asked to present documents in person at the address above.

New Freedom Program Requested (Select One):

□ Volunteer Driver Mileage Reimbursement Program □ Taxicab Program □ Door Assistance

APPLICANT INFORMATION

PERSONAL

Last Name	First Name	Middle Initial	Date of Birth

Home Address *(Number/Street/Apt No.)*	City	State	Zip Code

Home Phone	Cell Phone	E-mail Address

Preferred Method of Contact
☐ Home ☐ Cell ☐ E-mail

Gender
☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Decline to State

Mailing Address *(If different from home address)*	City	State	Zip Code

Employment Status
☐ Full or Part-time ☐ Retired ☐ Unemployed ☐ Decline to State

DEMOGRAPHICS

Client Race
☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hawaiian or Pacific Islander Japanese
☐ Black or African American ☐ Multiple Race ☐ Decline to State ☐ Other Race (Specify) _____

Client Ethnicity
☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to State

Primary Language Spoken/Used
☐ American Sign Language ☐ Arabic ☐ Armenian ☐ Cambodian ☐ Cantonese ☐ Chinese ☐ English
☐ Farsi ☐ French ☐ Korean ☐ Laotian ☐ Mandarin ☐ Japanese ☐ Russian ☐ Spanish ☐ Tagalog
☐ Thai ☐ Vietnamese ☐ Other (Specify) _____

Translation needed ☐ Yes ☐ No

EMERGENCY CONTACT

Contact Last Name	First Name	Middle Initial

Address *(Number/Street)*	City	State	Zip Code

Home Phone	Cell Phone	Relationship to Client

REFERRAL SOURCE

How did you hear about the programs?

☐ Senior Center ☐ Community Based Organization ☐ Outreach Event ☐ Project Room Key (PRK)

☐ Department Website ☐ Case Manager/Social Worker ☐ Other (Specify) _____

ADL / IADL RISK FACTORS

MOBILITY INFORMATION

Please state your level of assistance needed with the following daily activities:

Activities of Daily Living *(ADL)*

	Independent	Verbal Assistance	Some Human Help	A lot of Human Help	Dependent	Decline to State
Eating	☐	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐	☐
Transferring	☐	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐

Instrumental Activities of Daily Living *(IADL)*

	Independent	Verbal Assistance	Some Human Help	A lot of Human Help	Dependent	Decline to State
Meal preparation	☐	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐	☐
Medical Management	☐	☐	☐	☐	☐	☐
Money Management	☐	☐	☐	☐	☐	☐
Using Phone	☐	☐	☐	☐	☐	☐
Heavy Housework	☐	☐	☐	☐	☐	☐
Light Housework	☐	☐	☐	☐	☐	☐

DISABILITY FACTORS

Do you have a disability?

☐ Yes ☐ No

If yes, please check the type(s) of disability.

☐ Visually Impaired ☐ Hearing Impaired

☐ Speech Impaired ☐ Physically Impaired

☐ Memory Impaired ☐ Cognitively Impaired

Types of mobility aid(s) used

☐ Wheelchair ☐ Scooter ☐ Walker ☐ Cane

☐ Oxygen Tank ☐ Crutches ☐ Service animal

☐ None ☐ Other (Specify) _____

MOBILITY

Current means of transportation (Check all that apply)

☐ Family ☐ Friends ☐ Neighbor

☐ Personal vehicle ☐ Public Transit

☐ ACCESS ☐ Dial-A-Ride

☐ Uber/Lyft/Taxicab ☐ Other (Specify) _____

Most frequent trips made (Check all that apply)

☐ Medical facility ☐ Dental facility ☐ Pharmacy

☐ Personal ☐ Grocery Store ☐ Employment

☐ Place of Worship ☐ Senior Center

☐ Other (Specify) _____

MOBILITY SURVEY

MOBILITY MANAGEMENT

1) How would you rate your current overall quality of life?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2) Do you currently have difficulty accessing transportation?

☐ Yes ☐ No

If yes, please indicate why:

☐ Cost ☐ Disability ☐ Available services unknown ☐ Lack of services in your area

☐ Other (Specify) _____

3) Please indicate the impact access to transportation has on your quality of life:

☐ Negative ☐ Somewhat Negative ☐ Neutral ☐ Somewhat Positive ☐ Positive

4) In the past 6 months, how many medical and/or dental appointments have you missed due to a lack of transportation?

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ 11-15 ☐ More than 15

5) In the past 6 months, how many personal appointments have you missed due to a lack of transportation?

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ 11-15 ☐ More than 15

6) On average, how long does it take to travel to your medical and/or dental appointments?

☐ Less than 10 minutes ☐ 11-20 minutes ☐ 21-30 minutes ☐ More than 30 minutes

7) On average, how many times per month do you use public transit services?

☐ Zero ☐ 1-5 times ☐ 6-10 times ☐ 11-15 times ☐ More than 15 times

8) On average, how many days per month do you engage in social activities outside of your home?

☐ Zero ☐ 1-5 days ☐ 6-10 days ☐ 11-15 days ☐ More than 15 days

ACKNOWLEDGEMENT

CERTIFICATION

I have reviewed this application and certify that it is accurate and true to the best of my knowledge. I understand that the information I provide will be treated as confidential and will only be used to determine my initial and continuing eligibility for the program. I acknowledge that the participation in the Program is voluntary and does not involve public interests.

_____ _____

Applicant Signature Date

"Complete and return this application, along with copies of government issued ID"

If you are completing this form as an **authorized representative***, on behalf of the applicant, please print, sign, and date below to confirm the applicant's acknowledgement and acceptance of the above certification.

_____ _____ _____

Representative Name (Print) Representative Signature Date

*Documentation to act on behalf of the applicant may be requested.

Rev. 7.9.2020

VOLUNTEER DRIVER MILEAGE REIMBURSEMENT PROGRAM PARTICIPATION WAIVER

INDEMNIFICATION

In consideration of participation in the Volunteer Driver Mileage Reimbursement Program, the undersigned, or his or her personal representative, agrees to hold harmless Los Angeles County, Program staff, and Workforce Development, Aging, and Community Services Contractor, Independent Living Partnership, from any legal obligation or liability arising out of participation in the Volunteer Driver Mileage Reimbursement Program. The terms of this paragraph survive the termination of this program.

_____ (initial)

RELEASE AND WAIVER OF LIABILITY

The Participant agrees to *FOREVER RELEASE, DISCHARGE, AND WAIVE ANY AND ALL LIABILITY CLAIMS OR DAMAGES AGAINST* Los Angeles County, Program Staff, and Workforce Development, Aging, and Community Services Contractor, Independent Living Partnership, and all other participants in the Volunteer Driver Mileage Reimbursement Program ("Releasees") that the undersigned or his or her personal representative(s) has or might have against the Releasees, whether or not caused by the negligence of Releasees or any other person or entity, arising out of the Volunteer Driver Mileage Reimbursement Program.

_____ (initial)

ACKNOWLEDGEMENT

By signing the Volunteer Driver Mileage Reimbursement Program Indemnification Agreement (Agreement) and the Release and Waiver of Liability, the undersigned acknowledge(s): (1) that the participation in the Volunteer Driver Mileage Reimbursement Program is voluntary and does not involve public interests; (2) that the agreement has been read and understood; and (3) that the agreement is a contract that extinguishes certain legal rights and imposes other legal obligations. Failure to provide signatures where indicated above does not invalidate the agreement.

_____

Participant's Name (Printed) Participant's Signature Date