For Office Use Only: Safety _____ Transportation_____ Date Received: _____ Approve: Yes No Initials_____

New Client Application

ALL FIELDS ARE REQUIRED

NAME: _____ **DATE OF BIRTH** _____

HOME ADDRESS: _____ **VETERAN:** YES ___ NO ___

CITY, STATE, ZIP: _____ **HOME PHONE:** _____

MAILING ADDRESS (IF DIFFERENT): _____ **CELL PHONE:** _____

CITY, STATE, ZIP: _____ **EMAIL:** _____

MARITAL STATUS: MARRIED ☐ WIDOWED ☐ DIVORCED ☐ PARTNERED ☐ SINGLE ☐ OTHER ☐

GENDER: MALE ☐ FEMALE ☐ OTHER ☐ **NUMBER OF PEOPLE LIVING IN YOUR HOME:** _____

LIVING SITUATION: ALONE ☐ ALONE, WITH ASSISTANCE ☐ WITH SPOUSE ☐ WITH FAMILY ☐

WITH FRIENDS/ROOMMATES ☐ IN A GROUP HOME OR FACILITY ☐

ARE YOU OVER 60 YEARS OF AGE? YES ☐ NO ☐ **ARE YOU DISABLED?** YES ☐ NO ☐

IF YOU ARE UNDER 60, WHAT IS YOUR MOBILITY DISABILITY? _____

RACE: _____ **ETHNICITY:** HISPANIC ☐ NOT HISPANIC ☐

ARE YOU ON MEDICAID? YES ☐ NO ☐ **ARE YOU ON FOOD STAMPS?** YES ☐ NO ☐

ARE YOU ON MEDICARE? YES ☐ NO ☐ **ARE YOU ON SOC. SEC. DISABILITY?** YES ☐ NO ☐

IF YOU ARE A MEMBER OF A CHURCH, WHICH CHURCH: _____

EMERGENCY CONTACT: _____ **RELATIONSHIP TO CLIENT:** _____

ADDRESS: _____ **PHONE:** _____

CITY, STATE, ZIP: _____ **EMAIL:** _____

CLIENT ABILITY

DO YOU ACCESS THE INTERNET AND TECHNOLOGY REGULARLY: YES ☐ NO ☐

DO YOU RECEIVE VETERAN'S BENEFITS? YES ☐ NO ☐

CAN YOU GET IN AND OUT OF A VEHICLE WITHOUT ASSISTANCE? YES ☐ NO ☐

DO YOU USE A CANE, WALKER, OR WHEELCHAIR? CANE ☐ WALKER ☐ WHEELCHAIR ☐ NONE ☐

DO YOU OWN A CAR? YES ☐ NO ☐

DOES YOUR HEALTH PREVENT YOU FROM DRIVING LEGALLY AND SAFELY? YES ☐ NO ☐

WHAT SERVICES ARE YOU APPLYING FOR?

TRANSPORTATION TO MEDICAL APPOINTMENTS, GROCERY STORE, ETC.: YES ☐ NO ☐

MARK PREFERED VECHICLE SIZE: SMALL ☐ MEDIUM ☐ LARGE ☐ NO PICKUPS ☐ ANY VEHICLE ☐

GROCERY DELIVERY: YES ☐ NO ☐ **ADA ACCESS RAMP:** YES ☐ NO ☐

IN HOME MINOR SAFETY MODIFICATIONS: HANDRAIL ☐ GRAB-BAR ☐ OTHER _____

HOW DID YOU HEAR ABOUT INTERLINK? _____

CLIENT HEALTH

Please indicate the medical conditions that affect you.

INCONTINENCE: BLADDER ☐ BOWEL ☐ OTHER _____

VISION IMPAIRED: GLASSES ☐ BLINDNESS ☐ OTHER _____

BONE/ORTHOPEDIC DISORDER: OSTEOPOROSIS ☐ ARTHRITIS ☐ OTHER _____

HEARING: DEAFNESS ☐ HEARING AIDES ☐ HARD OF HEARING ☐ OTHER _____

COGNITIVE: MEMORY LOSS ☐ DEMENTIA ☐ ALZHEIMER'S ☐ OTHER _____

DEVELOPMENTAL DISABILITY: INTELLECTUAL DISABILITY ☐ TBI ☐ OTHER _____

RENAL CONDITION: DIABETES ☐ CHRONIC KIDNEY DISEASE ☐ OTHER _____

HEART CONDITION: ARRHYTHMIA ☐ HEART FAILURE ☐ OTHER _____

MENTAL/PSYCHOLOGICAL DISABILITY: BIPOLAR DISORDER ☐ SCHIZOPHRENIA ☐ OTHER _____

NEUROLOGICAL DISORDER: PARKINSON'S ☐ BRAIN TUMORS ☐ OTHER _____

RESPIRATORY DISORDER: ASTHMA ☐ COPD ☐ OTHER _____

SEIZURES: EPILEPSY ☐ OTHER _____

BALANCE DISORDER: DIZZINESS ☐ VERTIGO ☐ OTHER _____

HYGIENE/SELF-CARE CONCERNS: YES ☐ NO ☐ **LARGE/OBESE PERSON:** YES ☐ NO ☐

DO YOU SMOKE: YES ☐ **(**TOBACCO ☐ MARIJUANA (*WA CLIENTS ONLY*) ☐**)** NO ☐

ADDITIONAL SERVICES YOU USE

DIAL-A-RIDE: YES ☐ NO ☐ **COAST:** YES ☐ NO ☐

HOSPICE: YES ☐ NO ☐ **HOME HEALTH CARE SERVICES:** YES ☐ NO ☐

ADDITIONAL HOUSEHOLD INFORMATION

DO YOU OWN OR RENT YOUR HOME? OWN ☐ RENT ☐ OTHER _____

WHAT TYPE OF HOME? STICK-FRAME ☐ CONDO/APARTMENT ☐ FACILITY ☐ HOTEL/MOTEL ☐

MANUFACTURED HOME/TRAILER ☐ **DO YOU OWN OR RENT YOUR SPACE?** OWN ☐ RENT ☐ OTHER ☐

DO YOU LIVE IN ANOTHER'S HOME AS AN ADULT DEPENDENT? YES ☐ NO ☐

INCOME

PERSONAL GROSS ANNUAL INCOME: <$9,999 ☐ $10K-$15K ☐ $15K-$20K ☐ $20K-$35K ☐
$35-$50K ☐ $50K-$75K ☐ $75k+ ☐

HOUSEHOLD GROSS ANNUAL INCOME (IF DIFFERENT): <$9,999 ☐ $10K-$15K ☐ $15K-$20K ☐
$20K-$35K ☐ $35-$50K ☐ $50K-$75K ☐ $75k+ ☐

COVID-19 VACCINATION

INTERLINK DOES NOT DISCRIMINATE BASED ON VACCINATION STATUS, BUT REFUSAL TO PROVID THIS INFORMATION WILL FORCE INTERLINK TO ENTER YOUR STATUS AND NOT VACCINATED POTENTIALLY LIMITING YOUR SERVICE.

VACCINATED AGAINST COVID-19: YES ☐ NO ☐

SIGNED: _____ **DATE:** _____

Interlink, Inc. does not discriminate based on race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in any of its activities or operations

Interlink, Inc.
549 5th St, Suite E
Clarkston, WA 99403
509-751-9143

Volunteer Transportation Release

Both Rider Release and Rider Attestation MUST be signed to receive services from Interlink.

PRINT NAME: _____

1. **Rider:**

The undersigned assumes all reasonable risks involved in this service. I know that the driver is a volunteer and bears no responsibility for my health beyond safe point-to-point transportation. I know the driver Does Not Have first aid and CPR training. I also know the driver Does Not Have special training in passenger assistance techniques.

The undersigned understands and expressly assumes all the dangers of the service. The undersigned waives all claims arising out of the transport whether caused by negligence, breach of contract or otherwise, and whether for bodily injury, property damage or loss or otherwise, that I may ever have against Interlink, its successors and assigns, and its officers, directors, agents (e.g., volunteers), and employees, and their executors, administrators, and heirs.

SIGNED: _____ **DATE:** _____

2. **Rider Attestation:**

There is no reason or condition that may cause the above-named person difficulty during transit. The rider can enter and exit a vehicle under their own power. The rider may be transported in a sitting position in a private auto. Related to Interlink's volunteer transportation service, I hereby waive all claims, that I may ever have against the Interlink, its successors and assigns, and its officers, directors, employees, and agents (e.g., volunteers), and their heirs, executors, and administrators.

SIGNED: _____ **DATE:** _____

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Interlink, Inc.
549 5th St, Suite E
Clarkston, WA 99403
509-751-9143

MEMBER ENROLLMENT FORM

NAME: _____ **DATE OF BIRTH** _____

HOME ADDRESS: _____ **PHONE:** _____

CITY, STATE, ZIP: _____ **EMAIL:** _____

IF THIS MEMBERSHIP IS BEING PAID BY SOMEONE OTHER THAN THE MEMBER, PLEASE ENTER THEIR INFORMATION HERE.

PAYER NAME: _____ **PHONE:** _____

BILLING ADDRESS: _____ **EMAIL:** _____

CITY, STATE, ZIP: _____

PAYMENT METHOD:

CREDIT CARD ☐ ONLINE ☐ CHECK ☐

CONSIDER AUTOMATIC BILL PAY THROUGH YOUR BANK!

FOR CREDIT CARD, DEBIT CARD, AND OTHER ELECTRONIC PAYMENTS PLEASE FOLLOW THE "PAYPAL; SUBSCRIPTION" LINKS ON OUR WEBSITE:

WWW.INTERLINKVOLUNTEERS.ORG

IF YOU HAVE QUESTIONS OR WOULD LIKE A DIRECT LINK SENT TO YOU, PLEASE CONTACT THE INTERLINK OFFICE AT 509-751-9143.

SEND CHECK PAYMENTS TO:

INTERLINK, INC.

549 5TH STREET, SUITE E

CLARKSTON, WA 99403

Interlink, Inc.
549 5th St, Suite E
Clarkston, WA 99403
509-751-9143

INTERLINK CLIENT FEE WAIVER APPLICATION

TO REQUEST A FEE WAIVER (SUBSIDY), PLEASE FILL OUT AND RETURN THIS FORM ALONG WITH COPIES OF AT LEAST ONE OF THE FOLLOWING ITEMS:

1. **STATE MEDICAID CARD**
2. **STATE SNAP CARD**
3. **MEDICAID OR SSDI DETERMINATION LETTER**

I, _____, (PRINT FIRST & LAST NAME)

AM REQUESTING A SPONSORSHIP, VOUCHER, OR WAIVER FOR THE FOLLOWING: (PLEASE MARK CLEARLY)

☐ **MONTHLY MEMBERSHIP FEE FOR THREE MONTHS (VALUE: $50)**

☐ **RIDE FARES – MAXIMUM OF 3 BOARDINGS PER WEEK FOR 3 MONTHS (VALUE UP TO $120)**

☐ **ADA ACCESS RAMP (VALUE: $850)**

☐ **IN-HOME ACCESSIBILITY MODIFICATION (GRAB BARS, RAILINGS, ETC.) (VALUE: $100)**

- **I UNDERSTAND THAT FEE VOUCHERS ARE DEPENDENT ON DONATIONS FROM GENEROUS COMMUNITY MEMBERS AND ORGANIZATIONS AND SUCH FUNDS FOR VOUCHERS ARE NOT ALWAYS AVAILABLE.**
- **I UNDERSTAND THAT THESE FUNDS ARE LIMITED AND DISBURSED ON A FIRST-COME FIRST-SERVED BASIS.**
- **I UNDERSTAND THAT SUBMITTING THIS FORM IS NOT A GUARANTEE OF A VOUCHER AND THAT IF I RECEIVE SERVICES FROM INTERLINK WITHOUT RECEIVING A VOUCHER, I WILL BE RESPONSIBLE FOR ANY FEES OR COSTS ASSOCIATED WITH THOSE SERVICES.**
- **I UNDERSTAND THAT VOUCHERS ARE LIMITED AND ARE NOT EXPECTED TO BE GRANTED PERMANENTLY OR FOR ALL SERVICE REQUESTS.**
- **I UNDERSTAND THAT I WILL NEED TO REAPPLY FOR A FEE WAIVER/VOUCHER EVERY 3 MONTHS.**
- **I UNDERSTAND THAT IF IT IS DISCOVERED THAT THE INFORMATION PROVIDED HEREIN IS FALSE OR INACCURATE, I MAY BE BARRED FROM INTERLINK'S SERVICES FOR A PERIOD OF TIME DECIDED BY THE INTERLINK BOARD OF DIRECTORS.**

SIGNED: _____ **DATE:** _____

THE WAIVER/VOUCHER FUND FOR ASOTIN COUNTY TRANSPORTATION IS ALREADY PARTIALLY FUNDED TO SUBSIDIZE QUALIFYING ASOTIN COUNTY APPLICANTS*

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