



# New Freedom Transportation Application



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

County of Los Angeles – AD Department  
510 S. Vermont Ave., 11<sup>th</sup> Floor  
Los Angeles, CA 90020  
Attn: New Freedom Transportation



Or e-mail documents to: [newfreedom@ad.lacounty.gov](mailto:newfreedom@ad.lacounty.gov) with subject line “NFT Application.”  
Or submit an online application at: <https://ad.lacounty.gov/new-freedom-transportation/>

NFT Program Requested:

Volunteer Driver Mileage Reimbursement (VDMR) Program

## Applicant Information

<b>PERSONAL</b>	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 <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> E-mail			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Non-Binary <input type="checkbox"/> Decline to State				
	Mailing Address (If different from home address)				City		State	Zip Code
	Employment Status <input type="checkbox"/> Full or Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Decline to State							
<b>DEMOGRAPHICS</b>	Client Race <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian or Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Multiple Race <input type="checkbox"/> Decline to State <input type="checkbox"/> Other Race (Specify) _____							
	Client Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Decline to State							
	Primary Language Spoken/Used <input type="checkbox"/> American Sign Language <input type="checkbox"/> Arabic <input type="checkbox"/> Armenian <input type="checkbox"/> Cambodian <input type="checkbox"/> Cantonese <input type="checkbox"/> Chinese <input type="checkbox"/> English <input type="checkbox"/> Farsi <input type="checkbox"/> French <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Mandarin <input type="checkbox"/> Japanese <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Tagalog <input type="checkbox"/> Thai <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other (Specify) _____							
	Translation needed <input type="checkbox"/> Yes <input type="checkbox"/> No							
<b>EMERGENCY CONTACT</b>	Contact Last Name				First Name		Middle Initial	
	Address (Number/Street)				City		State	Zip Code
	Home Phone		Cell Phone		Relationship to Client			

<b>REFERRAL SOURCE</b>	How did you hear about the programs?
	<input type="checkbox"/> Senior Center <input type="checkbox"/> Community Based Organization <input type="checkbox"/> Outreach Event <input type="checkbox"/> Project Room Key (PRK) <input type="checkbox"/> Department Website <input type="checkbox"/> Case Manager/Social Worker <input type="checkbox"/> Other (Specify) _____

**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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Instrumental Activities of Daily Living (IADL)**

	Independent	Verbal Assistance	Some Human Help	A lot of Human Help	Dependent	Decline to State
Meal preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Money Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>DISABILITY FACTORS</b>	Do you have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, please check the type(s) of disability. <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Speech Impaired <input type="checkbox"/> Physically Impaired <input type="checkbox"/> Memory Impaired <input type="checkbox"/> Cognitively Impaired	Types of mobility aid(s) used <input type="checkbox"/> Wheelchair <input type="checkbox"/> Scooter <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Oxygen Tank <input type="checkbox"/> Crutches <input type="checkbox"/> Service Animal <input type="checkbox"/> None <input type="checkbox"/> Other (Specify) _____
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<b>MOBILITY</b>	Current means of transportation (Check all that apply) <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Neighbor <input type="checkbox"/> Personal vehicle <input type="checkbox"/> Public Transit <input type="checkbox"/> ACCESS <input type="checkbox"/> Dial-A-Ride <input type="checkbox"/> Uber/Lyft/Taxicab <input type="checkbox"/> Other (Specify) _____	Most frequent trips made (Check all that apply) <input type="checkbox"/> Medical facility <input type="checkbox"/> Dental facility <input type="checkbox"/> Pharmacy <input type="checkbox"/> Personal <input type="checkbox"/> Grocery Store <input type="checkbox"/> Employment <input type="checkbox"/> Place of Worship <input type="checkbox"/> Senior Center <input type="checkbox"/> On dialysis / ongoing scheduled treatment Treatment times in a week (2, 3x, 7x) _____ <input type="checkbox"/> Other (Specify) _____
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## MOBILITY MANAGEMENT

MOBILITY SURVEY

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

## CERTIFICATION

ACKNOWLEDGEMENT

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.



## VOLUNTEER DRIVER MILEAGE REIMBURSEMENT PROGRAM PARTICIPATION WAIVER

This waiver is an intentional and agreed upon release of rights. Your signature below ensures that Los Angeles County Aging & Disabilities Department Program staff and Contractor, Independent living Partnership, will be held harmless from any legal obligation or liability arising out of participation in the Volunteer Driver Mileage Reimbursement Program.

### 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 Aging & Disabilities Department 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 Aging & Disabilities 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 (Print)

\_\_\_\_\_  
Participant’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Representative Name (Print)

\_\_\_\_\_  
Representative Signature

\_\_\_\_\_  
Date