

**LOUDEN NELSON COMMUNITY CENTER
301 CENTER ST.
SANTA CRUZ, CA 95060**

**COMMUNITY BRIDGES - LIFT LINE
APPLICATION**

APPLICANT INFORMATION

First Name:		Middle Name:		Last Name:	
Date of birth:	Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No			Home Phone Number:	
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (specify): _____				Cell Phone Number:	

PICK UP ADDRESS (WHERE YOU WILL BE PICKED UP FOR TRANSPORTATION)

Current Home Address:					
City:		State:		ZIP Code:	
House	Apartment Complex	Mobile Home Park	Nursing Home	<i>(Please circle) Other: _____</i>	

MAILING ADDRESS (IF DIFFERENT FROM PICK UP ADDRESS)

Mailing Address (check here if same as above <input type="checkbox"/>):					
City:		State:		ZIP Code:	

EMERGENCY CONTACT

Name of a relative:			Home Phone Number:		
Address:			Cell Phone Number:		
City:		State:		ZIP Code:	
Relationship:					

DEMOGRAPHICS

Race/Ethnicity: <input type="checkbox"/> Caucasian <input type="checkbox"/> African-American <input type="checkbox"/> Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other(specify): _____					
Annual Household Income:		Household size:		Sex: Male Female NA	

TRANSPORTATION INFORMATION

Are you ambulatory (able to move around)?			Do you use a wheelchair?		
Size of wheelchair?			If so, are you able to transfer?		
Do you use any type of aids? <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Service dog <input type="checkbox"/> Other (Specify): _____					
Disability type: <input type="checkbox"/> Alzheimer <input type="checkbox"/> Dementia <input type="checkbox"/> Hearing impaired <input type="checkbox"/> Mental disability <input type="checkbox"/> Physical disability <input type="checkbox"/> Stroke <input type="checkbox"/> Visual impairment					
<input type="checkbox"/> Other (Specify): _____					

REQUIRED DOCUMENTS/VERIFICATION

Are you under the age of 60 <i>(Please circle)</i> ? Yes No					
If you are under the age of 60, you will need to provide proof of disability with your application: <input type="checkbox"/> Doctor's note <input type="checkbox"/> ParaCruzID <input type="checkbox"/> State Disability <input type="checkbox"/> Other (Specify): _____					
Income verification (please include copy with application): <input type="checkbox"/> Income Tax <input type="checkbox"/> Social Security <input type="checkbox"/> Other (Specify): _____					

PLEASE COMPLETE THE FOLLOWING IF PERSON OTHER THAN APPLICANT FILLED OUT THE APPLICATION

Name:			Title:		
Relationship to client:		Signature:		Date:	

SIGNATURES

By signing below I certify that the information contained herein is accurate to my knowledge:					
Print Name:				Date:	
Signature of applicant:					

OFFICE USE ONLY

Date received:	Approved for: <input type="checkbox"/> TDA <input type="checkbox"/> OOC <input type="checkbox"/> VA <input type="checkbox"/> TS _____	Letter sent date:	Database Entry:
Received by:	<input type="checkbox"/> Other: _____ Approved by:	Initials:	Initials: