

Date: \_\_\_\_\_

**EASY RIDE CLIENT INFORMATION**

**Phone: 303-464-5534**

280 Spader Way Broomfield, CO 80020

Last Name: \_\_\_\_\_ Legal First Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth\*: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Female Male Other Do you live alone? Yes No

\*If you are under the age of 60, do you have a disability as defined under the Americans with Disabilities Act (ADA)?  
Yes No If yes, you must provide us with a statement, on letterhead, from a medical provider verifying that you have a disability as defined under the ADA.

If you live alone, is your monthly income **below \$1,041 per month**? Yes No

If you have a spouse or partner, is your monthly household income **below \$1,409 per month**? Yes No

Residential Address: \_\_\_\_\_ Apartment/ Unit #: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County (circle): Broomfield Adams Jefferson

**Mobility:** Ambulatory Cane Walker  
Other: \_\_\_\_\_

**Wheelchair:** Regular Electric Scooter

**Transfers from chair to Bus seat:** Yes No

**Will the rider have an escort?** Yes No

**Unstable, needs assistance:** Yes No

**Are you able to walk up and down four stairs?** Yes No

**Transported with Oxygen?** Yes No

**Medical Conditions (circle all that apply):**

**Vision Impaired** (cannot be corrected with glasses)

**Hearing Impaired** (cannot be corrected with hearing device)

**Dementia**

**Frail**

**Other** (describe any other conditions that our drivers need to know):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What is your race:**

Asian/Pacific

Black/African American

Caucasian/White

Hispanic/Latino

Native American

Other: \_\_\_\_\_

**Are you Hispanic/Latino?**

Yes No

**Are you a veteran?**

Yes No

Emergency Contact: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Secondary Emergency Contact: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

*I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service provider and I herewith give my consent to do so. (If filled out by assessor or via phone, please have assessor check here and sign below ☐).*

Signature \_\_\_\_\_

Date \_\_\_\_\_

Office use only  
Filled out by: \_\_\_\_\_  
Date: \_\_\_\_\_

**Please read the following information concerning this Intake Form and Complaint/Grievance Procedure:**

We are asking you to complete the attached form to the best of your knowledge so we understand how you would like to receive services. Some basic information (\*) is needed to meet compliance with federal and state reporting requirements and to target consumers age 60 and older who have the greatest economic and social need, such as individuals who are low-income minority, frail, and rural. Requests for services are processed as funds allow.

Your income level is not used to qualify you to receive services, but rather as a means to gather demographic data to various entities to show the need for continued funding of services. Nobody will contact you, unless you choose so in order to receive information about services which might be available to you.

Complaint/Grievance/Appeal Procedure is

- To ensure fair and equitable treatment of all consumers, eliminate dissatisfaction, resolve problems and
- To establish complaint and appeals procedures that inform the consumers of their rights to complain and receive a written response at the provider level

Any OAA/OCA (Older Americans Act/Older Coloradans Act) eligible consumer who has a complain/grievance with the organization asking you to fill out this assessment form has the right to file a complaint/grievance with said organization and, if not satisfied with the organization's decision, to appeal that decision with either the local AAA (Area Agency on Aging) or the SUA (State Unit on Aging).

The complete Complaint/Grievance/Appeal Procedure is available upon request by contacting your local AAA and/or the SUA as follows:

Office of Community Access and Independence  
Aging and Adult Services  
1575 Sherman Street, 10<sup>th</sup> Floor  
Denver, CO 80203  
(303) 866-2800 (Main Line)  
(303) 866-2977 (Fax)  
(888) 866-4243 (Toll Free)

**Contributions:**

Any person receiving services shall have the opportunity to contribute towards the cost of the service. No eligible person shall be denied a service because of their inability and/or choice not to contribute.