Para-transit application form

Completed application form must be signed by a qualified health care professional to certify that the applicant meets the eligibility requirements.

Personal information on this form is collected under the authority of the Municipal Act, R.S.O. 1990, Chapter M.45 (as amended).

Eligibility criteria

- The applicant is unable to use conventional transit service due to their physical functional mobility

I am a new customer applying to: (please check all that apply)

Burlington Handi Van _____

Oakville care-A-van _____

Milton *access+* _____

I am an existing customer (ID#_____)

Personal information:

Mr ○ Mrs ○ Miss ○ Ms ○

Last name: _____ First name: _____

Date of birth: _____

Address: _____

Name of residence (if applicable): _____

Day time phone: _____ Evening phone: _____

Preferred method of contact for service delay in excess of 30 minutes:

Phone or email: _____

In case of emergency, please notify:

Name: _____

Phone numbers: _____ or _____

Relationship to applicant: _____

I am applying for: (please check one)

Unconditional eligibility_____

- A person whose physical functional mobility prevents them from using conventional transit services

Temporary eligibility_____

- A person whose temporary physical functional mobility prevents them from using conventional transit services

Conditional eligibility_____

- A person whose physical functional mobility due to environmental or physical barriers limit their ability to consistently use conventional transit services

Authorization: application must be signed by the applicant or Power of Attorney (POA)

I hereby authorize the representative of the service providers (Burlington Handi Van, Oakville care-A-van or Milton Paratransit) to use this application to determine my eligibility. This application will be reviewed by the representative of the service providers for the purpose of determining my eligibility for their respective service.

I also authorize the health care professional who signed Part B to release any information to the representative of the service providers for purposes of determining eligibility. I understand that I may be asked to attend an in-person interview with a representative of the respective service provider to assist in the assessment of my eligibility. I also understand that my continued eligibility may be re-assessed from time to time by the service provider with whom I am approved.

SIGNED_____DATED_____

*Application will not be processed without the signature of the applicant, guardian or POA.

Note:

Applications will be processed within 14 calendar days.

Applicants will be notified by mail whether the application has been approved or denied.

Application can be mailed, faxed or emailed to:

Para-Transit Application Office
c/o Oakville Transit
1225 Trafalgar Road
Oakville, ON L6H 0H3
Fax: 905-338-4166
mobility@oakville.ca

PART A

Section 1

How does your physical functional mobility affect your ability to use conventional transit services? (Please provide any information you feel would be useful)

_____
_____
_____
_____

How do you currently travel?

_____
_____

Section 2

Do you require any of the following to ride conventional transit services? (Please check all that apply)

- Manual wheelchair ☐
- Powered wheelchair ☐
- Powered scooter ☐
- Walker ☐
- Prosthesis ☐
- Hearing aid ☐
- Communication board ☐
- Oxygen bottle ☐
- Service animal ☐
- Crutches ☐
- Cane ☐
- White cane ☐
- Other _____

If you checked yes to any of the above please circle the response below

- Are you able to board a low floor, ramp equipped conventional bus on your own? Yes ○ No ○ Sometimes ○
- Are you able to get in a car without assistance Yes ○ No ○ Sometimes ○
- Are you physically able travel to a regular bus stop Yes ○ No ○ Sometimes ○

- Are you generally able to wait outside at a regular bus stop Yes ○ No ○

  If you circled No, please complete:
  I can wait outside at a bus stop only **IF**
  There is a bench ☐
  There is a shelter ☐
  The wait is no longer than _____minutes ☐

Section 3

Travelling by conventional transit service requires that you are able to access the bus stops along the route.

- I can get to and from a bus stop only **IF** (check all that apply):
- I have an attendant with me ☐
- I am familiar with the area ☐
- There is a sidewalk ☐
- The path of travel is free of ice, snow, or debris ☐
- I do not have to cross a busy street ☐
- I am familiar with the bus route ☐
- I need to travel less than _____ feet to or from a bus stop from my residence ☐
- I receive travel training* for the stops I use ☐

  **travel training is a support program that instills knowledge and confidence to travel independently on conventional transit service*

- There are curb cuts along the route to the bus stop ☐
- The ground is level or only slightly inclined ☐
- Other _____

I can independently recognize my destination and leave the bus Yes ○ No ○

I can recognize my destination and leave the bus only IF (check all that apply):

- I receive travel training ☐
- The driver announces my stop ☐
- Other
  _____

PART B

To be completed by a health care professional

Applicant's name:_____

I have read Part A in its entirety Yes _____ No _____

Do you agree with the information in Part A. Yes _____ No _____

If NO please explain:

_____
_____
_____
_____
_____

Does the applicant require any of the following to ride para-transit services?

Manual wheelchair
Powered wheelchair
Powered scooter
Walker
Prosthesis
Hearing aid
Communication board
Oxygen bottle
Service animal
Crutches
Cane
White cane
Other _____

Conditions causing the impact to the physical functional mobility of the applicant:

_____
_____
_____
_____

Does the applicant require a support person to ride on board a bus?
(i.e. they are not able to self-direct their own care while on board the vehicle)

Yes_____ No _____

Expected duration of the disability

- Temporary: expected until YY_____Month_____Day_____
- Permanent: conditions with no expectation of improvement

Is there any other information which impacts the physical functional mobility of the applicant?

Yes ____ No _____

If yes, please explain:-

_____
_____
_____
_____

Profession: (Please check one)

Licensed Physician
Registered Nurse
Licensed Physical Therapist
Registered Occupational Therapist
Chiropractor
Certified Rehabilitation Specialist
Other :_____

I hereby certify that the above information is true:

Name: (Please print) _____

License/Certification Number: _____

Address: _____

Telephone: _____ Fax: _____

Email: _____

Signature: _____

Date: _____