



OAKVILLE TRANSIT

430 Wyecroft Road, Oakville, ON L6K 2G7

Oakville care-A-van Mailing Address

1225 Trafalgar Road
Oakville, ON L6H 0H3

Fax: 905-338-4166

Phone: 905-337-9222

Eligibility Guidelines

Oakville care-A-van is intended for anyone who, due to a physical functional mobility challenge, is **unable to board regular Oakville Transit buses or walk a distance of 175 metres (an average block).**

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



A. PERSONAL INFORMATION

Last Name Mr. Mrs. Miss Ms. First Name

Street Address and Name Apartment/Suite/Unit #

City/Town Postal Code Date of Birth (dd/mm/yr)

Name of Residence Telephone: Home Business



B. EMERGENCY CONTACT

Please provide a name to be contacted in case of emergency.

Last Name Mr. Mrs. Miss. Ms. First Name Relationship to Client

Street Address and Name Apartment/Suite/Unit # City/Town

Postal Code Telephone: Home Business



C. AUTHORIZATION

I hereby authorize the Oakville care-A-van to use this application to determine my eligibility. This application will be reviewed by members of these organizations as well as advisory committees for the purpose of determining my eligibility for their respective services. I also authorize the signing health care professional to release any information to those same providers for purposes of determining eligibility. I also understand that my continued eligibility may be reassessed from time to time to the providers with whom I am approved.

For Office Use Only

Applicant's Signature _____ Date _____

To be filled out by Health Professional

E. HEALTH PROFESSIONAL INFORMATION

Last Name Dr. Mr. Mrs Miss Ms. First Name

Street Address and Name Suite/Unit # City/Town

Postal Code Phone Number Fax Number

- CPSO (Physician) BDPT (Physiotherapist) OSOT (Occ. Therapist) BDC (Chiropractor)
 RN (Registered Nurse) Other _____

F. DISABILITY INFORMATION

Diagnosis of physical disability - Describe in detail the physical restrictions and how they affect his/her mobility.

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Is the applicant physically able to board a regular transit bus? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Is the applicant physically able to walk a distance of 175m (600ft an average block)? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Is the applicant able to transfer from wheelchair to car with minimal assistance? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Does the applicant suffer from vertigo to the degree that s/he would fall? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Does the applicant require an attendant/escort? (i.e. they are <u>not</u> able to self direct own care, or to be left unattended aboard the vehicle) |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Is the applicant cognitively impaired? If so, to what degree? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Does the applicant use mobility aids (Please indicate circle which one(s))
wheelchair electric wheelchair scooter walker cane(s) crutches leg braces other |

Are there any other factors limiting the applicant's ability to use regular transit services? Please explain

Health Care Professional's Signature _____ Date _____