

### Eligibility Guidelines

Special Transit Services are intended for persons who are **physically unable to climb or descend steps used in conventional transit facilities**, or walk a distance of 175 metres (approximately 600 feet.) Persons who are blind or have emotional problems and/or mental disabilities may be eligible for Special Transit Services in some cases. 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		
<input type="text"/>		<input type="text"/>		
Street Address and Name		Apartment/Suite/Unit #		
<input type="text"/>		<input type="text"/>		
City/Town	Postal Code	Date of Birth (dd/mm/yr)		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Name of Residence	Telephone: Home	Business		
<input type="text"/>	<input type="text"/>	<input type="text"/>		

## 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
<input type="text"/>		<input type="text"/>	<input type="text"/>
Street Address and Name		Apartment/Suite/Unit #	City/Town
<input type="text"/>		<input type="text"/>	<input type="text"/>
Postal Code	Telephone: Home	Business	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

## C. AUTHORIZATION

I hereby authorize the Oakville care-A-van, and/or Red Cross 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.

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- | Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Is the applicant physically able to climb/descend stairs on 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) to a bus stop?  |
| <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. is able to self direct own care, would be able to be left safely 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))<br>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

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Health Care Professional's Signature \_\_\_\_\_ Date \_\_\_\_\_