



Application for the Regional Inter-Municipal Specialized Transit Services “Niagara Specialized Transit”

Mailing Address

Application Number _____

Niagara Region
Public Works Dept.
2201 St. David’s Road
P.O. Box 1042
Thorold, ON
L2V 4T7
Attn. Transit Manager

Please complete and return this form
in person, by mail, or fax to 905-685-0013

For more information, call 905-680-4821
or 1-866-487-7765

Eligibility Guidelines

- 1) The inter-municipal specialized service is intended for persons who would be unable to board a conventional bus or walk a distance of 175 metres.
- 2) Cognitively impaired and visually or hearing impaired may be eligible if they have a physical disability that would prevent them from boarding a conventional bus or walking 175 metres.

The service is only available to those travelling from one municipality to another for a medical appointment. A medical appointment is defined as an appointment with a medical/health practitioner, or an institution providing medical services, all licensed and/or funded by the Province of Ontario

Personal Information

(Circle one)

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

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Street – Address and Name Home Phone Number

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

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Name of Residence if Applicable

Residence Phone Number

If you are currently using any other municipal specialized transit service, please name them. _____.

Emergency Contact

Please provide a person to be contacted in case of an emergency

(Circle One)

Last Name Mr., Mrs., Miss., Ms.

First Name

Relationship

Street – Address and Name

City/Town

Postal Code

Home Phone Number

Work Number

Cell Phone

Authorization

I hereby authorize the Niagara Region to use this application to assess my eligibility. This application will be reviewed by members of this organization as well as the Eligibility Committee for the purposes of determining my eligibility for the inter-municipal specialized service. I also authorize the signing medical/health care professional to release any information to the Region for purposes of determining eligibility. I also understand that this information may be released to The Red Cross Niagara, the service deliverer, and that my continued eligibility may be assessed from time to time. I also agree that I will abide by all of the Rules and Operating Procedures of the Region of Niagara.

Applicants Signature _____ Date _____

Or Power of Attorney _____ (dd/mm/yr)

The personal information that is collected by the Region is collected under the authority of the *Municipal Act, 2001, S.O. 2001, c.25* as amended, and is used solely for the administration of the inter-municipal specialized transit service. This information is held in strict confidence. You have the right to access this information or ask questions about it by contacting the Region’s Corporate Records Manager at (905) 685-1571, ext. 3741 for answers.

Medical/Health Practitioner 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	Email Address

- Licensed Physician
- Licensed Therapist
- Registered Nurse
- Licensed Optometrist/Ophthalmologist
- Other (Specify) _____
- Registered Occupational Therapist
- Certified Psychologist/Psychiatrist
- Licensed Chiropractor

Disability Information

1) How is this person’s mobility affected? (This question must be completed)

- | | Yes | No |
|---|--------------------------|--------------------------|
| 2) Would the applicant be physically able to board a conventional bus? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Is the applicant able to walk a distance of 175 metres? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Is the applicant at risk of falling due to vertigo? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Does the applicant require a Personal Care attendant?
(unable to self direct own care or unable to be left unattended aboard the vehicle) | <input type="checkbox"/> | <input type="checkbox"/> |

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Application Number _____

6) Please check the items that he/she will have with them when they board a vehicle.

- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Service Animal | <input type="checkbox"/> Cane |
| <input type="checkbox"/> Powered Wheelchair | <input type="checkbox"/> Oxygen | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Powered Scooter | <input type="checkbox"/> Crutches | <input type="checkbox"/> White Cane |
| <input type="checkbox"/> Other (Specify) _____ | | |

7) For what time period will the applicant require the inter-municipal specialized service?

Temporary Length of Time _____ Permanent

Are there other factors limiting the applicants functional mobility? Please Explain.

Medical/Health Practitioner Signature

Date

(dd/mm/yr)