

# Milton Transit

## Accessible Transit Application Form



### Eligibility Guidelines:

Accessible Transit Services are intended for persons who are physically unable to climb or descend steps as used in conventional transit, and unable to walk a distance of 175 metres (approximately 600 feet).

### Applicant Instructions:

Applicant should complete sections A, B, and C. The applicant's health care professional to complete sections D and E.

## A. Personal Information

Last name	Mr. Mrs. Miss. Ms.	First name	Date of birth (dd/mm/yr)	Age
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Street address and name	Apartment/Suite/Unit #	City/Town	Postal Code	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Name of residence	Main intersection nearest home			
<input type="text"/>	<input type="text"/>			
Telephone: Home	Telephone: Business			
<input type="text"/>	<input type="text"/>			

## B. Emergency Information

*Please provide two contacts to be contacted in case of emergency. One must be at a different address and phone number and one must be next of kin.*

Last name	Mr. Mrs. Miss. Ms.	Last name	Mr. Mrs. Miss. Ms.
<input type="text"/>		<input type="text"/>	
First name	Middle initial	First name	Middle initial
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Street address and name	Unit #	Street address and name	Unit #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
City/Town	Postal code	City/Town	Postal code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Relationship to applicant	Relationship to applicant		
<input type="text"/>	<input type="text"/>		
Telephone: Home	Business	Telephone: Home	Business
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## C. Applicant's Authorization

I understand that this application will be reviewed for the purpose of determining my eligibility for Accessible Transit service. I also authorize the signing health care professional to release any information to the provider for purposes of determining eligibility. I also understand that my continued eligibility may be re-assessed from time to time by the provider.

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Date

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Applicant's Signature

This application form will not be processed without the signature of the applicant or the applicant's guardian.

Please allow 2 - 3 weeks to process your application.

The Town of Milton will notify all applicants regarding whether their application has been accepted or not accepted.

### For Office Use Only

Received by: Coordinator, Transit, Community Services

Application:  Accepted  Denied

Processed by: \_\_\_\_\_

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



### Mail, fax, or drop-off to:

Milton Transit  
Community Services Department  
Town of Milton  
150 Mary Street  
Milton, Ontario  
L9T 6Z5

fax: (905) 864-3222

## D. Health Care Professional Information

*(The following two pages are to be completed by a health care professional ONLY)*

Last name	Dr. Mr. Mrs. Miss. Ms.	First name	Middle initial
<input type="text"/>		<input type="text"/>	<input type="text"/>
Street address and name	Suite/Unit #	City/Town	Postal code
<input type="text"/>		<input type="text"/>	<input type="text"/>
Phone Number	Fax Number	<input type="checkbox"/> CPSO (Physician)	
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> BDPT (Physiotherapist)	
		<input type="checkbox"/> BDC (Chiropractor)	
		<input type="checkbox"/> OSOT (Occ. Therapist)	
		<input type="checkbox"/> RN (Registered Nurse)	
		<input type="checkbox"/> Other _____	

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## E. Disability Information

Diagnosis of physical disability

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List applicant's physical restrictions and how they affect his/her mobility

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Is/does the applicant:

	Yes	No
Physically able to climb/descend stairs on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>
Physically able to walk a distance of 175m (600 ft - an average block)?	<input type="checkbox"/>	<input type="checkbox"/>
Able to transfer from wheelchair to car with minimal assistance?	<input type="checkbox"/>	<input type="checkbox"/>
Suffer from vertigo to the degree that s/he would fall?	<input type="checkbox"/>	<input type="checkbox"/>
Require an attendant/escort? (i.e. is unable to self-direct own care and would be unable to be left safely unattended aboard the vehicle or while in transit)	<input type="checkbox"/>	<input type="checkbox"/>
Cognitively impaired? If so, to what degree? _____	<input type="checkbox"/>	<input type="checkbox"/>

Does the applicant use mobility aids?  Yes  No

If so, please indicate which one(s)

- |                                     |  |
|-------------------------------------|--|
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Electric Wheelchair |
| <input type="checkbox"/> Scooter    | <input type="checkbox"/> Walker              |
| <input type="checkbox"/> Cane(s)    | <input type="checkbox"/> Crutches            |
| <input type="checkbox"/> Leg Braces | <input type="checkbox"/> Other: _____        |

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

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For what time period are special transit services required?

- Temporary: Length of Time: \_\_\_\_\_
- Permanent

Does Applicant live alone?  Yes  No

Will applicant make his/her own bookings?  Yes  No

If no, will applicant be aware of booking?  Yes  No

Is service being requested for applicant

- In town transportation
- Out of town transportation
- Both

**I hereby certify that the information given above is correct**

\_\_\_\_\_

Date

\_\_\_\_\_

Health Care Professional Signature