Tel: 613-930-2636
Fax: 613-932-9906
Website: www.cornwalltransit.ca

APPLICATION FOR HANDI-TRANSIT SERVICE

Important Information About Handi-Transit

Handi-Transit is a door-to-door shared ride accessible public transit service for people with disabilities. Applicant may be eligible for Handi-Transit if they reside within Cornwall city limits and have a disability that prevents them from using conventional, low-floor transit service for part or all of the time.

Handi-Transit Operators will assist passengers from the exterior door of the pick-up and drop-off locations.

Conventional (Regular) Transit Buses are all wheelchair accessible and have equipment (including ramps, no steps entrances and low-floors) to assist individuals with disabilities. We encourage clients to become independent by offering a Support Card to an assisting person who would accompany clients that would like to use the regular bus system. This will not affect your status as a Handi-Transit registrant. Conventional Transit Service may be a better alternative for those who want greater independence and flexibility.

Support Card is not needed to accompany clients on Handi-Transit.

All Transit bus operators have received special training on how to assist persons with disabilities.

Cornwall Transit also operates a fully accessible Community Service Bus Route that stops at shopping centres, senior residences, the Hospital some Medical Centres.

Eligibility for Handi-Transit

You could be eligible due to a visual, sensory, cognitive or physical disability for a short-term or long-term period. Disability alone does not create eligibility. The decision is based on the applicant's functional ability to use conventional low-floor transit. It is not a medical decision, nor is it based on the applicant's income or age. The unavailability of conventional transit service does not constitute eligibility.

All personal information on your application is confidential and solely for the purpose of determining eligibility for Handi-Transit. It is also protected under the authority of The Freedom of Information and Protection Act (FIPPA) and /or The Personal Health Information Protection Act.

Please make sure to fill out this application carefully and completely. Eligibility will be based on the information provided on this form and service will be provided to those who have the greatest functional need for Handi-Transit's accessible service.

Cornwall Transit attempts to provide service to as many approved registered clients as possible, not all trips may be accommodated due to availability and increasing demand for service.

How to Apply:

This two-part application (Part A by applicant and Part B by health care professional) must be fully completed, signed by you and your health care professional. The fully completed application must be returned to Cornwall Transit.

Cornwall Transit will review your completed application within 14 days of receiving the application. Your level of eligibility will be determined by Handi-Transit based on the information you provided in the application. Any incomplete or unclear information on parts A and B of the form will delay the application process or be refused.

If we require additional information about how your disability affects the use of Cornwall Transit's regular fixed-route or low floor services, we may have to speak to your health care professional.

You may be required to renew your application as needed to ensure updated eligibility information.

If approved, a registration card with information on how to use the service will be mailed to you.

If you have any questions or need assistance to complete this application form, please call Cornwall Transit at 613-930-2636.

IMPORTANT:

These two information pages are part of the application. Please keep attached.

PART A

Handi-Transit

☐ New applicant: Administration use only Client ID # _____

☐ Renewal: Date Received: _____ Expiry Date: _____

TO BE COMPLETED BY THE APPLICANT (Please print clearly)

Name: _____ Male [ ] Female [ ]
(Last) (First) (Middle)

Home Address _____
(Number) (Street) (Apt)

_____
(City) (Postal Code)

Home Phone: _____ Cell Phone: _____

Date of Birth: _____
MONTH (by name)/DD/YYYY

Contact Person Information in case of emergency

Emergency Name: _____ **Home: ( )** _____

Address: _____ **Cell: ( )** _____

Email: _____

Relationship to applicant: _____

1. Please check which primary mobility aid(s) you will be using when riding on the Handi-Transit?

[ ] Manual wheelchair
[ ] ***Manual Lightweight (transport chair)
[ ] Cane
[ ] White cane
[ ] Oxygen bottle
[ ] Other _____
[ ] **Not applicable**
[ ] Powered wheelchair
[ ] ***Powered scooter
[ ] Walker
[ ] Crutches
[ ] Service animal (attach copy of certification)

***** Must be able to transfer independently to a bus seat for safe transportation.

2. Please describe the environmental or physical barriers which affects your ability to use the conventional low-floor fixed-route transit? _____

_____

3. **How far is the closest bus stop from your home:**_____

4. **Does your home have steps outside at the pickup door? Yes [ ] No [ ]**

   If yes, how many: _____

   Do you need assistance to go up or down these steps? Yes [ ] No [ ]

   - **Note**: Handi-Transit operators will provide assistance to and from the accessible building doors (no more than one step stairs) when requested.

5. **Do you require a seatbelt exemption? Yes [ ] No [ ]**

   If yes, for safety reasons: All Handi-Transit registrants are required to wear a seatbelt/shoulder strap. Unless a medical exemption due to health reasons at which time we will need a letter from the doctor.

6. **If using a wheelchair, provide the outside dimensions.**

   Width of wheelchair:_____ Length of wheelchair**:**_____

   Important Note:

   - All wheelchair lifts measure 30" wide x 50" long. (76cm x 127cm)
   - Maximum Combined weight of passenger and mobility aid may not exceed 800lbs (363 kg).

   Any equipment exceeding those measurements or weight shall not be accommodated, for passenger safety.

7. **All mobility aids must be kept in good working condition in order to be transported**.
   - Does your wheelchair/scooter have a lap belt? **Yes [ ] No [ ]**
   - Does your wheelchair have footrests? **Yes [ ] No [ ]**

By signing below, I make this solemn declaration conscientiously believing it to be true to the best of my knowledge. I hereby authorize my health care professional to release any information which may be required to establish my eligibility for Handi-Transit

_____

Signature of Applicant (or person completing the information) Date: _____

Information of non-applicant:

Name: _____ Relationship to applicant: _____

Address: _____ Daytime Phone Number: _____

_____

Handi-Transit

PART B:

TO BE COMPLETED BY A HEALTH CARE PROFESSIONAL

You are being asked by the Handi-Transit applicant (named in Part A) to provide information regarding his/her ability to use Handi-Transit opposed to Conventional Transit's fixed-route services.

Please read the information on the first two pages as well as Part A provided by the applicant.

NOTE: Handi-Transit is not a service for persons who occasionally, experienced difficulty in using Regular Transit's fixed-route service, replacing someone's automobile. Fill in and sign Part B, basing your evaluation solely on the applicant's ability or inability to use conventional transit all or some of the time.

Persons with a disability would generally be considered eligible for Handi-Transit service if by attempting to use Cornwall Transit's regular low floor fixed-route transit service, their health would be **endangered** or the attempt would **likely lead to bodily harm.**

The information you provide will allow us to evaluate the request and to provide the appropriate service. Thank you for your cooperation in this matter. **Be aware incomplete or unclear information may be returned for clarification.**

Charges for completing this form (or for obtaining additional information) are the responsibility of the applicant. If you have any questions about Conventional Transit Services or Handi-Transit please contact us at 613-930-2636

1. **I have read the information pages and Part A in its entirety. Yes [ ] No [ ]**
2. **Please provide your preferred method of communication should we require further information and/or clarification?**_____
3. **Does the applicant require a door to door driver assisted transportation service due to the nature of their disability? Yes [ ] No [ ]**
4. **What is the applicant's diagnosis and how does the disability prevent him/her from using conventional transit services?**

5. **Does the applicant's disability fluctuate from day to day, or with environmental conditions, to prevent him/her from using conventional transit buses at times?**

   No [ ] Yes [ ] if yes, what are the barriers_____

   _____
6. **How long have you treated or known the applicant?** _____

7. Based on the accessible features on Cornwall Transit vehicles (listed on page 1), is the applicant able to physically board and ride on conventional transit?

Yes [ ] No [ ] If no, explain why: _____

_____

8. Do you feel that the applicant requires a support person to attend to their own needs while riding the bus, due to health and/or safety reason?

No [ ] Yes (cannot ride alone) [ ] Sometimes: [ ]

Explain: _____

9. What cage of eligibility best fits the applicant's disability?

[ ] unconditional eligibility [ ] temporary eligibility [ ] conditional eligibility

10. In your opinion, what is the estimated time the applicant will need the Handi-Transit Service? Months: _____ Years: _____

Note: If the applicant needs our service while in rehabilitation and the address is different than applicant's home address, for pick-up purposes, provide us with the temporary address and duration of rehabilitation if longer than 3 months.

Applicant's Address while in Rehab: _____

I certify that I am currently a regulated, licensed and/or accredited health-care professional and, that the information above in Part B of this application is accurate and complete to the best of my knowledge.

Signature of Health Care Professional _____ Date: _____

Print Name: _____ Telephone Number: _____

_____

Street Address City Province Postal Code

Profession (check one)

[ ] Licensed physician
[ ] Registered physical / occupational therapist
[ ] Certified psychologist
[ ] Nurse Practitioner
[ ] Certified rehabilitation specialist
[ ] RN only if in nursing or long term care home

THANK YOU FOR YOUR ASSISTANCE

Please return this completed application to the person seeking Handi-Transit

or Mail or Fax to:

Cornwall Handi-Transit Eligibility
863 Second Street West
Cornwall, Ontario K6J-1H5 or Fax: 613-932-9906