

Specialized Transit Application Form

Complete this form to apply for specialized transit service in the City of Burlington, Town of Milton, and/or Town of Oakville.

Specialized transit is an accessible shared ride service for persons with a disability that prevents them from using conventional transportation services.

How to complete this form

Part A – Applicant Information: The applicant, guardian or power of attorney is to complete and sign.

Part B – Healthcare Professional: A healthcare professional must complete and sign Part B of the form providing information on the applicant's disability.

Forms are processed within 14 calendar days and applicants will be notified by email, when provided, or by mail whether the application has been approved or denied.

Completed applications can be faxed to 905-338-4166, emailed to mobility@oakville.ca or mailed to: Specialized Transit Application Office c/o Oakville Transit, 1225 Trafalgar Road Oakville, ON L6H 0H3

Applications can be delivered to Oakville Transit at 430 Wycroft Road, Oakville.

Collection of Information

Personal information contained on this form is collected under the authority of the Municipal Act, 2001, S.O. 2001, c. 25, to determine eligibility for specialized transit service in the City of Burlington, Town of Oakville and/or Town of Milton and to communicate specialized transit service information and engagement opportunities. Questions about this collection can be directed to



3332 Harvester Rd., Burlington
905-639-0550
contactbt@burlington.ca



150 Mary St., Milton
905-864-4141
transit@milton.ca



OAKVILLE
TRANSIT

430 Wycroft Road, Oakville
905-815-2020
transit@oakville.ca

Part A: Applicant

I am a New Customer Existing Customer

My Customer ID is

I am applying to Burlington Transit Milton access+ Oakville care-A-van

I will primarily use specialized transit in Burlington Milton Oakville

First Name

Last Name

Street Address

Unit #

City/Town

Postal Code

Name of Residence (if applicable)

Date of Birth

Day-time Phone Number

Evening Phone Number

Email

Cellular Number

Preferred method of contact for a known service delay in-excess of 30minutes:

Phone Email

In case of emergency, please notify

Name

Relationship to applicant

Home Phone Number

Cellular Number

Within the last 6 months, have you used conventional transit? Yes No

Are you:

Able to board a low floor, ramp equipped conventional bus on your own? Yes No

Are you able to travel to a regular bus stop? Yes No

Are you able to wait outside at a regular bus stop? Yes No

If you answered no above, can you wait outside if

There is a bench Yes No

There is a shelter Yes No

The wait is not longer than min.

I can get to and from a bus stop only if (check all that apply):

- I have an attendant with me
- I am familiar with the area
- There is a sidewalk
- The path of travel is free of ice, snow, or debris
- I do not have to cross a busy street
- I am familiar with the bus route
- I need to travel less than ft to or from a bus stop from my residence
- There are curb cuts along the route to the bus stop
- The ground is level or only slightly inclined

I can independently recognize my destination and leave the bus: Yes No

I can recognize my destination and leave the bus only if (check all that apply):

- The driver announces my stop
- Other

Explain how you are unable to use conventional transit due to your disability (Please share all information that would support your need for specialized transit)

How do you currently access your community? (grocery store, appointments, friends, family, etc.)

- | | | | |
|---|-------------------------------------|--|-------------------------------|
| <input type="checkbox"/> Public Transit | <input type="checkbox"/> GO Transit | <input type="checkbox"/> Car | <input type="checkbox"/> Taxi |
| <input type="checkbox"/> Walk | <input type="checkbox"/> Bicycle | <input type="checkbox"/> Ride Share (Uber, Lyft, etc.) | |

What assistive devices do you use? (Please check all that apply)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Powered wheelchair | <input type="checkbox"/> Powered scooter | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Hearing aid | <input type="checkbox"/> Communication board | <input type="checkbox"/> Oxygen bottle |
| <input type="checkbox"/> Certified Service animal | <input type="checkbox"/> Crutches | <input type="checkbox"/> Cane | <input type="checkbox"/> White cane |

Other

Which assistive devices do you use the most?

Applicant Signature and Authorization

I hereby authorize the representative of the service providers (Burlington Transit, Oakville care-A-van or Milton access+) to use this application to determine my eligibility. This application will be reviewed by the representative of the service providers for the purpose of determining my eligibility for their respective service.

I also authorize the healthcare professional who signed Part B to release any information to the representative of the service providers for purposes of determining eligibility. I understand that I may be asked to attend an in-person interview with a representative of the respective service provider to assist in the assessment of my eligibility. I also understand that my continued eligibility may be re-assessed from time to time by the service provider with whom I am approved.

Signature Dated

If you are the parent, guardian or power of attorney for the applicant, complete the following:

First Name Last Name
Street Address Unit #
City Postal Code
Day-time Phone Number Evening Phone Number
Email Cellular Number
Relationship to Applicant
Signature Dated

Form Checklist

Please use the following checklist to ensure your application is complete

- I have signed Part A
- I have completed all the questions
- My Healthcare Professional has completed Part B including certification number and contact information
- My Healthcare Professional has signed Part B
- I have made a copy of the form (Optional)

Part B: Healthcare Professional

To be completed by a certified healthcare professional.

Applicant's full name

I have read Part A in its entirety Yes No

Do you agree with the information in Part A? Yes No

If No, please explain

Does the applicant require any of the following to ride transit services?

(Please check all that apply)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Powered wheelchair | <input type="checkbox"/> Powered scooter | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Hearing aid | <input type="checkbox"/> Communication board | <input type="checkbox"/> Oxygen bottle |
| <input type="checkbox"/> Certified Service animal | <input type="checkbox"/> Crutches | <input type="checkbox"/> Cane | <input type="checkbox"/> White cane |

Other

Can the applicant travel to a bus stop and are they able to board a low-floor, ramp equipped conventional transit bus? Yes No

If No, please explain

Is the disability permanent without expectation of change? Yes No

If not permanent, the disability is temporary until

Is the applicant undergoing a surgical procedure? Yes No

What is the date of the procedure?

What is the procedure?

Indicate using the chart below the applicant's

	Condition/Diagnosis	How it affects the applicant's ability to use conventional transit
Physical		
Cognitive		
Mental Health		
Sensory		
Seizure		
Other: _____		

Does the applicant require a mandatory support person? Yes No

Can the applicant walk 175 m? Yes No

Is the applicant at risk of falling down? Yes No

Is the applicant at risk of inadvertently exiting the vehicle and wandering? Yes No

Is there any other information which is relevant to this application? Yes No

Healthcare Professional Signature and Authorization

Profession: (Please check one)

- | | |
|--|--|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Licensed Physician |
| <input type="checkbox"/> Registered Nurse | <input type="checkbox"/> Licensed Physical Therapist |
| <input type="checkbox"/> Registered Occupational Therapist | <input type="checkbox"/> Certified Rehabilitation Specialist |
| <input type="checkbox"/> Physiotherapist | |

Other

I hereby certify that the above information is true:

First Name <input style="width: 315px; height: 30px;" type="text"/>	Last Name <input style="width: 315px; height: 30px;" type="text"/>
Street Address <input style="width: 505px; height: 30px;" type="text"/>	Unit # <input style="width: 150px; height: 30px;" type="text"/>
City <input style="width: 395px; height: 30px;" type="text"/>	Postal Code <input style="width: 145px; height: 30px;" type="text"/>
License/Certification Number <input style="width: 460px; height: 30px;" type="text"/>	
Day-time Phone Number <input style="width: 215px; height: 30px;" type="text"/>	
Email <input style="width: 645px; height: 30px;" type="text"/>	
Signature <input style="width: 450px; height: 45px;" type="text"/>	Dated <input style="width: 190px; height: 45px;" type="text"/>