City of Niagara Falls – Specialized Transit (Chair-A-Van) Application Form

Completed application form must be signed by a qualified health care professional to certify that the applicant meets the eligibility requirements.

Personal information on this form is collected under the authority of the Municipal Act, R.S.O. 1990, Chapter M.45 (as amended).

Completed application can be mailed, faxed or emailed to:

Niagara Chair-A-Van
St. John Ambulance
5734 Glenholme Avenue
Niagara Falls, ON L2G 4Y3
Phone: 905-357-0122
Fax: 905-357-7199
ncav@cogeco.net

Eligibility criteria
The applicant is unable to use conventional transit service due to a permanent or temporary disability.

Personal information:
Mr.☐ Mrs.☐ Miss☐ Ms.☐

Last name: _____ First name: _____

Date of birth: _____

Address and Postal Code: _____

Name of residence (if applicable): _____

Day time phone: _____ Evening phone: _____

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

Phone or email: _____

In case of emergency, please notify:

Name: _____

Phone numbers: _____ or _____

Relationship to applicant: _____

I am applying for (please check one):

☒ **Unconditional eligibility**
A person whose disability prevents them from using conventional transit services

☐ **Temporary eligibility**
A person whose temporary disability prevents them from using conventional transit services

☐ **Conditional eligibility**
A person whose disability due to environmental (i.e. seasonal) or physical barriers limit their ability to consistently use conventional transit services

Authorization

Application must be signed by the applicant or Power of Attorney (POA)

I hereby authorize the representative of the service providers for Niagara Chair-A-Van 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 health care professional who signed Part B to release any information to the representative of the service providers for purposes of determining 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.

SIGNED _____ **DATED** _____

*Application will not be processed without the signature of the applicant, guardian or POA.

PART A – To be filled out by the applicant

Section 1

How does your disability affect your ability to use conventional transit services? (Please provide any information you feel would be useful)

How do you currently travel?

Section 2

Do you require any of the following to ride conventional transit services?
(Please check all that apply)

- ☐ Manual wheelchair
- ☐ Powered wheelchair
- ☐ Powered scooter
- ☐ Walker
- ☐ Prosthesis
- ☐ Hearing aid
- ☐ Communication board
- ☐ Oxygen bottle
- ☐ Service animal
- ☐ Crutches
- ☐ Cane
- ☐ White cane
- ☐ Other _____

Please check the response below

Are you able to board a low floor, ramp equipped conventional bus on your own?
Yes ☐ No ☐

Are you able to get in a car without assistance Yes ☐ No ☐

Are you physically able travel to a regular bus stop Yes ☐ No ☐

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

If you check No, please complete:
I can wait outside at a bus stop only **IF**

- ☐ There is a bench
- ☐ There is a shelter
- ☐ The wait is no longer than _____ minutes

Section 3

Travelling by conventional transit service requires that you are able to access the bus stops along the route.

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

☐ Do not have to cross a busy street

☐ I am familiar with the bus route

☐ I need to travel less than ___feet to or from a bus stop from my residence

☐ I receive travel training* for the stops I use

**travel training is a support program that instills knowledge and confidence to travel independently on conventional transit service*

☐ There are curb cuts along the route to the bus stop

☐ The ground is level or only slightly inclined

☐ Other _____

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):

☐ I receive travel training

☐ The driver announces my stop

☐ Other _____

PART B - To be completed by a health care professional

Applicant's 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 para-transit services?

- ☐ Manual wheelchair
- ☐ Powered wheelchair
- ☐ Powered scooter
- ☐ Walker
- ☐ Prosthesis
- ☐ Hearing aid
- ☐ Communication board
- ☐ Oxygen bottle
- ☐ Service animal
- ☐ Crutches
- ☐ Cane
- ☐ White cane
- ☐ Other

Conditions causing the impact to the physical functional mobility of the applicant:

Does the applicant require a support person to ride on board a bus?
(i.e. they are not able to self-direct their own care while on board the vehicle)
Yes ☐ No ☐

Expected duration of the disability

- Temporary: expected until YY _____ Month _____ Day _____
- Permanent: conditions with no expectation of improvement ☐

Is there any other information which impacts the physical functional mobility of the applicant?

Yes ☐ No ☐

If yes, please explain

Profession: (Please check one)

☐ Licensed Physician
☐ Registered Nurse
☐ Licensed Physical Therapist
☐ Registered Occupational Therapist
☐ Chiropractor
☐ Certified Rehabilitation Specialist
☐ Other : _____

I hereby certify that the above information is true:

Name: (Please print) _____

License/Certification Number: _____

Address: _____

Telephone: _____ Fax: _____

Email: _____

Signature: _____ Date: _____

Office Use Only

Approved Date _____

Notes: _____