

Application for Specialized Transit

Complete this form to apply for specialized transit service in the Town of Halton Hills.

Specialized transit is an accessible shared ride service for persons with a disability and/or seniors age 65 or older.

How to complete this form

Part A – Applicant Information: The applicant, guardian or power of attorney is to fully complete and sign Part A of this application. Applicants age 65 or older that do not have a disability and/or do not require a caregiver for travel are not required to complete section Part B of this application form, and must provide proof of age for eligibility purposes.

Part B – Healthcare Professional: A healthcare professional must complete and sign Part B of this form providing information on the applicant's disability. Applicants age 65 or older that do not have a disability and/or do not require a caregiver for travel are not required to complete section Part B of this application form.

Application forms are processed within seven (7) calendar days upon receipt. Applicants will be sent a confirmation registration package by mail.

Completed applications can be sent by fax to 905-873-8192; email activan@haltonhills.ca or by mail:

Town of Halton Hills c/o ActiVan

1 Halton Hills Drive
Halton Hills, ON. L7G 5G2

Collection 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 Town of Halton Hills and to communicate specialized transit service information and engagement opportunities. Questions about this collection can be directed to the Town's Transit Supervisor at 905-873-2600, ext. 2617 or activan@haltonhills.ca

Town of Halton Hills

Transportation and Public Works

1 Halton Hills Drive, Halton Hills ON L7G 5G2
General Inquiry: 905-702-6435
Fax: 905-873-8192
Website: haltonhills.ca/transit
Email: activan@haltonhills.ca



Application for Specialized Transit

I am a New Customer Existing Customer

My previous Customer ID is: _____

I will primarily use: ActiVan Specialized Transit Taxi Scrip Program Both services

Part A: Applicant

Personal Information

Name: _____

Date of Birth (mm/dd/yy): _____

Address: _____

Apartment/Suite or Unit: _____

City or Town: _____ Postal Code: _____

Day-time Phone: _____ Evening Phone: _____

Cellular Phone: _____

Subscribe to the ActiVan email list to receive newsletters and updates: Yes No

Email: _____

Emergency Contact Information

Name: _____

Day-time Phone: _____ Evening Phone: _____

Relationship to applicant: _____

Name: _____

Day-time Phone: _____ Evening Phone: _____

Relationship to applicant: _____



Are you:

Able to board a low floor, ramp equipped specialized vehicle on your own? Yes No
Able to independently recognize your destination and leave the vehicle? Yes No

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

The driver announces my stop
 Other: _____

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

GO Transit Car Taxi
 Walk Bicycle Ride Share (Uber, Lyft etc.)

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

Manual wheelchair Powered wheelchair Powered Scooter
 Walker Prosthesis Hearing aid
 Communication board Oxygen bottle Certified service animal
 Crutches Cane White cane
 Other: _____

Which assistive device do you use the most?

Applicant Signature and Authorization

I hereby authorize the representative of the Town of Halton Hills ActiVan service to use this application to determine my eligibility. I acknowledge this application will be reviewed by a representative of the ActiVan service for the purpose of determining my eligibility.

Applicant's Signature

Date (mm/dd/yy)



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

Name: _____

Date of Birth (mm/dd/yy): _____

Address: _____

Apartment/Suite or Unit: _____

City or Town: _____ Postal Code: _____

Day-time Phone: _____ Evening Phone: _____

Cellular Phone: _____ Email: _____

Relationship to applicant: _____

Signature

Date (mm/dd/yy)

Registration Checklist

I have applied as a senior age 65 and older:

- I have signed Part A.
- I have completed all questions.
- I am over the age of 65 and do not have a disability and/or require a caregiver for travel. I have attached proof of age to this application.
- I have made a copy of the application for my records (optional).

I have applied as a person with a disability:

- I have signed Part A.
- I have completed all questions.
- My healthcare professional has fully completed Part B including contact information.
- My healthcare professional has signed Part B.
- I have made a copy of the application for my records (optional).

Part B: Healthcare Professional

To be completed by a 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?

- | | | |
|--|---|---|
| <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 |
| <input type="checkbox"/> Other _____ | | |

Is the applicant able to board a low floor, ramp equipped vehicle on their own? 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(s) (mm/dd/yy): _____

Indicate using the chart below the applicant's:

	Condition/Diagnosis	How it affects the applicant's ability when using specialized transit
Physical		
Cognitive		
Mental Health		
Sensory		
Seizure		
Other		

Does the applicant require a support person for travel?

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

In a transportation situation, does the applicant exhibit behaviours (impulsiveness, aggressiveness) that could be detrimental to their safety or to the safety of others on board? Yes No

If yes, please explain

Are there conditions which affect the applicant's safety in the community, please specify:

Does the applicant understand safety risks in the community? Yes No

Is the applicant at risk for wandering or becoming lost in the community? Yes No

Can the applicant be safely left unattended on board while the driver assists other passengers? Yes No

Other:

Is there any other information which is relevant to this application?



Healthcare Professional Signature and Authorization

Profession (please check one)

- Chiropractor
- Registered Nurse
- Registered Occupational Therapist
- Certified Rehabilitation Specialist
- Physiotherapist
- Other _____
- Licensed Physician
- Licensed Physician Therapist

I hereby certify that the above information is true:

Name: _____

Address: _____ Suite or Unit: _____

City or Town: _____ Postal Code: _____

Telephone: _____ Fax: _____

Signature

Date (mm/dd/yy)

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