

Service de transport adapté
MRC de Brome-Missisquoi
455, rue Yamaska est
Farnham (Qc)
J2N 1J2

APPLICATION FOR ELEGIBILITY FOR PARATRANSIT

Instructions to applicant:

1. Fill in Part 1, "General Information".
2. Have Part 2, on disabilities, filled in by the professional :
 - Most familiar with the disability or disabilities that are the basis for your application for eligibility for paratransit;
 - You consult regularly or who treats you or provides you with rehabilitation or re-education services.

That professional may be :

- an occupational therapist, physiotherapist or physiatrist;
 - a cardiologist, pneumologist or neurologist;
 - a spatial orientation and mobility specialist;
 - a rehabilitation or re-education specialist;
 - a psychologist or psychiatrist;
 - any other professional of the health network or education network..
3. When parts have been duly filled in, send the form to the paratransit eligibility committee to this address :

<p>MRC Brome-Missisquoi Comité D'admission 455, rue Yamaska Est Farnham (Québec) J2N 1J2 Téléphone : 450-293-8583 Fax : (450) 293-7874 E-Mail : transport@mrcbm.qc.ca</p>
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The purpose of the questions in this application is to identify the applicant's limitations with respect to mobility and to determine whether their impact justifies the use of paratransit services. Consequently,

ANY FORM THAT IS INCOMPLETE OR ILLEGIBLE WILL HAVE TO BE RETURNED TO THE APPLICANT. THIS WILL DELAY PROCESSING OF THE APPLICATION.

APPLICATION FOR ELIGIBILITY

Reserved for office use		
File No. _____		
Date of receipt Day _____	Year _____	Month _____
of application _____		

Part 1- General Information

This part is to be filled in by the applicant, a person designated by the applicant or, if the applicant is unable to act, by the authorized person (legal representative).

The information provided is treated confidentially and is for the exclusive use of the eligibility committee.

PRINT IN BLOCK LETTERS

NOTE : Any form that is incomplete or illegible will be returned to the applicant.

1- Identification of applicant.

Family name			Given name		
Home address	Number	Street		Apartment No.	
Municipality				Postal code	
Name of institution where applicant is living (if applicable)				Room No.	
Telephone No	Home () -		Office () -		
Date of birth	Year	Month	Day	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Weight
				Height	

2- What is your main impairment ? _____

Since when have you had it ? _____

Do you have other impairments ? Specify : _____

3- What problems caused by your impairment(s) have led you to apply for paratransit ?

Are the problems : Permanent ? Seasonal ?

Temporary? Probably for a period of _____

Intermittent ? Specify the circumstances _____

4A- What aids do you use regularly to make it easier to get around outside ?

- Accompanying person
- Walker
- Cane
- Long touch-the-ground cane (white)
- White support cane
- Crutches
- Guide dog
- Service dog
- Motorized wheelchair

- Rigid manual wheelchair
- Folding manual wheelchair

Can you get from your wheelchair into an automobile seat ?

- Yes, unassisted
- Yes, with help
- Never, even with help
- 3-wheel power chair
- 4-wheel power chair
- Other (e.g. orthesis, other type of chair...), specify _____

4B- If you use any of these aids only on occasion, specify when and in what circumstances.

5- If there is a public transit service in your municipality, are you able to use it ?

No. Explain _____

Yes: Bus Subway Do you need to be accompanied? Always Sometimes Never

6- Do you have dependant children under 14 ?

No Yes Name(s) and date(s) of birth _____

7- If you were declared eligible for paratransit, would you need special help while in the vehicle (in transit) ?

No Yes, Specify _____
Why? _____

8- How are you able to communicate ?

Verbally With sign language With symbols In no way at all
 In some other way, specify _____

9- Do you use

a teleprinter No Yes
 another communication device No Yes, specify _____

10- Is there a professional resource other than the one responsible for completing the attestation of disability (appended) that the eligibility committee can contact if need be for help in analysing your application ?

Name	Position
Name of institution (if applicable)	
Telephone No. () -	Permit No. (if applicable)

Additional information bearing on your eligibility or use of paratransit can be attached separately.

11- If someone other than the applicant is completing this part of application, that person is to be identified in this section.

Family name		Given name	
Telephone No.	Home () -	Office () -	Extension
Relation to applicant		Name of institution (if applicable)	

12- Person to contact in an emergency.

Family name		Given name	
Telephone No.	Home () -	Office () -	Extension
Relation to applicant		Name of institution (if applicable)	

I certify that the information provided is correct. I understand that any false declaration could result in my being declared ineligible or in the cancellation of my eligibility.

Mandatory signature

Applicant

Authorized person, if applicant is unable to act

Authorization by applicant

I authorize the eligibility committee to read the information contained in this form and in all the appended supporting documents. I also authorize the committee to contact the persons identified above and the persons who prepared the documents. I understand that, if declared eligible, only the information required for my comfort and safety will be disclosed to the carrier.

Mandatory signature

Applicant

Authorized person, if applicant is unable to act

Date

Note : The content of this form is prescribed by the ministère des Transports du Québec.

ATTESTATION OF DISABILITY

Who may fill out this form ?

It is important that this part of the form to be filled in by **a professional familiar with the limitations** to mobility caused by the person's impairments.

- an occupational therapist, physiotherapist or physiatrist;
- a cardiologist, pneumologist or neurologist;
- a spatial orientation and mobility specialist;
- a rehabilitation or re-education specialist;
- a psychologist or psychiatrist;
- any other professional of the health network or education network.

Important !

Be careful to fill out this section correctly. Otherwise, processing of the application and access to paratransit will be delayed.

SECTION 1 Physical and motor disabilities

(Fill in if applicable. Otherwise, go directly to section 2).

1- Is the person able to walk 400 metres on level ground ?

- Yes
- Yes, except in winter
- Yes, but certain geographical obstacles prevent the applicant from doing so. Specify

-
- Yes, except when travelling with a child under six years of age for whom the applicant is responsible
 - No, never
 - No, except intermittently. Specify : _____

Specify how far the applicant is able to walk (in metres) _____

Time required _____

2- Is the person able to go up a step 35 centimetres high with support, or down the step without support ?

- Yes
- Yes, except when travelling with a child under six years of age for whom the applicant is responsible
- No. Applicant is unable at all times to : step up with support step down without support

Explain (amplitude, muscular weakness, pain, balance)

3- ***Does a severe and chronic cardiac or respiratory insufficiency or a severe neurological impairment make the applicant extremely susceptible to fatigue, and therefore unable to make an entire trip using public transit or would prevent it if such transit were available in the applicant's municipality ?***

No Yes, at all times. Explain _____

Yes, intermittently, explain _____

If this disability involves only trips made to undergo dialysis, specify _____

4- ***Are the disabilities identified in questions 1 to 3***

Permanent Temporary, specify their probable duration _____

5- ***What diagnosis has been entered in the applicant's file in relation to the disabilities previously identified (e.g. multiple sclerosis, CVA, hemiplegia) ?***

When ? _____

Specify, if applicable, the level of impairment or the functional status (degree, class), in particular the functional class of respiratory or cardiac impairment (NYHA) or of Parkinson's disease.

Specify the prostheses used, if any _____

6- ***Do the applicant's disabilities make the use of any of the following aids necessary for getting around outside ?***

Motorized wheelchair 3-wheel power chair Walker Crutches
 Manual wheelchair 4-wheel power chair Canes Service dog

Other (e.g. orthosis, other type of chair), specify _____

The applicant needs this aid At all times Occasionally

Explain _____

If the applicant uses a wheelchair, is he or she able to get from the wheelchair into a automobile seat ?

Yes, without help
 Yes, with help
 No, not even with help

SECTION 2 Sensory, cognitive or behavioural disabilities

(Fill in if applicable. Otherwise, go directly to section 3).

1- Is the applicant able to keep track of time or find his or her bearings ?

Yes No

This disability is evident

- At all times Only after dark Only in winter
 For trips in unfamiliar surroundings
 For complicated trips
 Intermittently, explain
-

2- When travelling (e.g. crossing the street), is the applicant able to master situations that could compromise his or her safety (or that of his or her children) ?

Yes No

This disability is evident

- At all times Only after dark Only in winter
 For trips in unfamiliar surroundings
 For complicated trips
 For trips made with a child or children under 6 years of age
 For trips including dangerous intersections
 Intermittently, explain
-

3- When travelling, is the applicant able to master behaviour (e.g. impulsiveness, aggressiveness, self-mutilation) that could compromise his or her safety or that of others ?

Yes No

If not, specify when this disability is evident.

- At all times, explain _____
 Intermittently, explain _____
 In certain situations, explain _____

Does the applicant have a behavioural problem that the carrier should know about if the applicant is declared eligible ?

No Yes, specify _____

4- Are the disabilities identified in question 1 to 3 :

Permanent ? Temporary ? specify their probable duration _____

5- What diagnosis has been entered in the applicant's file in relation to the disabilities previously identified (e.g. trisomy 21 syndrome, schizophrenia, retinitis pigmentosa) ?

When ? _____

6- *If the applicant has a psychological or psychiatric disorder, does he or she take medication for it ?*

No Yes

If the answer is yes, are the problems controlled by the medication ? Explain _____

7- *If the applicant has a visual impairment, specify his or her*

Visual acuity : corrected distance vision (in metres)

OD _____ OS _____ OU _____

Visual field : check where appropriate and explain

Less than 20° OD OS _____

More than 20° OD OS _____

What mobility aids does the person require ?

None Telescopic aid Long touch-the-ground cane (white) Electronic aid

Support cane (white) Service dog Other, specify _____

8- *If the applicant is epileptic :*

Indicate whether the problem is controlled through medication Yes No Partially

If partially, specify whether

A form of medication is being tested, explain _____

No medication has brought attacks completely under control, explain _____

Explain the nature of the attacks (type and manifestations)

If the applicant has serious attacks (i.e. with loss of consciousness or convulsions), give the average number of times a week they occur.

Specify any side effects of the medication used

Explain, if applicable, in what way the applicant's safety is at risk while he or she is travelling.

9- *Is the person able to communicate ?*

Verbally Using symbols

Using sign language In no way at all

In some other way, explain (deafness) _____

SECTION 3 It is mandatory to have this section filled in by the professional.

1- Has the applicant undergone, is he or she undergoing, or will he or she be undergoing treatment or rehabilitation?

Yes, supervised by _____ Telephone No. _____

Name of institution _____

Ongoing or upcoming services _____

Beginning date _____ Probable duration _____ End date _____

Is the applicant able to use regular public transit or will the applicant be able to use regular public transit following the treatment or rehabilitation ?

Yes No, explain _____

2- Has the applicant taken, is he or she taking, or will he or she be taking a course in spatial orientation and mobility, a learning activity or a familiarization activity (treatment or behaviour therapy) with a view to using regular public transit services ?

Yes supervised by _____ Telephone No. _____

Name of institution _____

(if different from that given under question 1 in this section)

Beginning date _____ Probable duration _____ End date _____

If the course in spatial orientation and mobility, the learning activity or the familiarization activity was not a success, explain why.

No. If the applicant has not had, or is not expected to have, the benefit of a course in spatial orientation and mobility, a learning activity or a familiarization activity, give the reasons.

The applicant does not have learning or familiarization potential, explain _____

The applicant has learning or familiarization potential, but no public transit is offered in the municipality

The travel routes are too complicated

The travel routes are considered dangerous

The travel routes needed are not covered by the regular public transit service

The travel routes are not taken often enough to maintain safe travel behaviour

The applicant (or the applicant's parent or tutor) refuses. Give the reasons _____

None was applied for

Other, specify _____

3- Is the applicant able to make certain trips using regular public transit without an accompanying person ?

- No, the applicant is not able to do so
- No, since the service is not available in the area where the applicant lives
- Yes, all trips
- Yes, all trips, except after dark
- Yes, all trips, except in winter
- Yes, all trips, except when travelling with a child under 6 years of age for whom the applicant is responsible
- Yes, certain specific trips

Specify the points of departure and arrival for these trips

Departure

Arrival

4- If the applicant were declared eligible for paratransit, would an accompanying person be required in transit because of the applicant's disabilities ?

- No, explain _____
- No, provided a certain measures were taken to alleviate behavioural problems, explain _____

- Yes, temporarily, for a period of familiarization lasting _____
- Yes, at all times, explain _____
Would the applicant be able to use regular public transit while accompanied ?
 - Yes
 - No, explain _____

5- Is it likely that the applicant will recover from his or her present condition ?

- Yes, say when and explain _____

- No, explain _____

6- Since when have you been treating or provided services to the applicant ?

7- Specify the source of the information on diagnosis and the evaluation of disability provided in this from..

- An evaluation of the applicant. Specify, if applicable, the type of evaluation undergone by the applicant – e.g. a study muscle and joint function

- The applicant's file
- Diagnosis, specify date _____
- Evaluation of disability, specify date _____

Other, specify _____

8- Please provide any additional information or append any document that you feel should be brought to the attention of the eligibility committee for the purposes of this application.

This form was filled out by :

Name _____ Position _____

Telephone No. _____ Permit No. (if applicable) _____

I certify that the information provided is correct. I understand that any false declaration could result in the applicant's being declared ineligible for paratransit or in the cancellation of the applicant's eligibility.

Signature of authorized professional _____ Date _____

Stamp or seal of professional
or of rehabilitation centre

The content of this form is prescribed by the ministère des Transports du Québec