



## St. Catharines Transit Commission

**Paratransit System Application Form. Please complete this form and mail or deliver it to:**

The Paratransit System of St. Catharines  
2012 First Street Louth, R.R. #3  
St. Catharines, Ontario  
L2S 3V9  
Office Hours 8:30 a.m. - 4:00 p.m., all working weekdays  
Tel. 905-685-9844 Fax. 905-685-4050

**The information provided on this application is of a confidential manner, and is for the sole use of acceptance for service on The Paratransit System of St. Catharines. It is protected from access by *The Freedom of Information and Protection of Privacy Act, 1987.***

**This Application is subject to review by the Paratransit Application Review Committee at any time.**

**Please read the following carefully.**

**A. Eligibility Criteria** as regulated by the Province of Ontario.

1. Paratransit is a service for persons who have **physical** disabilities that result in their inability to use regular bus service. This refers to persons who are **physically unable to:**
  - (i) **Board a regular bus**, which involves climbing or descending three steps or,
  - (ii) **Walk a distance of 175 metres.**
2. Persons with mental or cognitive disabilities, or the elderly or blind, may be eligible for specialized transit, but only on the basis that they have **physical** disabilities that prevent them from boarding regular buses or walking a distance of 175 metres.

**B. Completion of Application Form:**

1. Fill out all parts of the form that apply to you.
2. Provide your name, address, and telephone number.
3. Your physician must specify the exact nature and severity of your disability stating why you are unable to physically use regular buses and sign this form.
4. Be sure to sign your Application Form, or have someone sign on your behalf.

Registration may take up to four (4) weeks, providing all the required information is received and you clearly meet the eligibility criteria. You will receive more details after your application has been reviewed by the Review Committee.

**Paratransit service is only available to those persons whose physical disability prevents them from using the regular bus service.**

**1. Applicant:**

Please complete all sections in full

Surname (Please print) \_\_\_\_\_ First Name \_\_\_\_\_ Init. \_\_\_\_\_ Mr/Mrs/Miss/Ms \_\_\_\_\_

Street Number and Name \_\_\_\_\_

\_\_\_\_\_ Postal Code \_\_\_\_\_

St. Catharines, Ontario

Name of Residence (if appropriate) \_\_\_\_\_

Please state the main intersection nearest your residence \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Alternate Phone No. Ext. \_\_\_\_\_ Date of Birth \_\_\_\_\_  
905- \_\_\_\_\_ 905- \_\_\_\_\_ Day Month Year \_\_\_\_\_

**Do you require Paratransit service:**

permanently? yes \_\_\_\_\_ no \_\_\_\_\_  
seasonally (due to weather)? yes \_\_\_\_\_ no \_\_\_\_\_ If yes, which months? \_\_\_\_\_  
temporarily? yes \_\_\_\_\_ no \_\_\_\_\_ If yes, how many months? \_\_\_\_\_

**Are you currently using the regular bus service?** yes \_\_\_\_\_ no \_\_\_\_\_  
If yes, why do you now require Paratransit service? \_\_\_\_\_

**Do you use a walking aid of any kind?** (ie. cane, two canes, three point cane, four point cane, crutches, walker, leg brace) Please specify. \_\_\_\_\_

**Do you utilize a mobility aid of any kind, when travelling?** yes \_\_\_\_\_ no \_\_\_\_\_

Please Specify: \_\_\_\_\_  
Wheelchair \_\_\_\_\_ (manual / electric) Manufacturer \_\_\_\_\_  
Scooter \_\_\_\_\_  
Stroller \_\_\_\_\_  
Other: \_\_\_\_\_

**Our employees are only permitted to assist users up or down one vertical step.**

Are there any steps at the entrance to; your home? yes (how many) \_\_\_\_\_ no \_\_\_\_\_  
your workplace? yes (how many) \_\_\_\_\_ no \_\_\_\_\_  
your Doctors? yes (how many) \_\_\_\_\_ no \_\_\_\_\_  
other (specify)? \_\_\_\_\_ yes (how many) \_\_\_\_\_ no \_\_\_\_\_

What means of transportation are you using at the present time?  
\_\_\_\_\_

Were you previously registered with Paratransit? yes \_\_\_\_\_ no \_\_\_\_\_ year \_\_\_\_\_

Have you applied for Paratransit service in the past? yes \_\_\_\_\_ no \_\_\_\_\_ year \_\_\_\_\_

**Applicant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**SECTIONS 2 & 3 must be completed by your Health Care Professional (Please print clearly)**

Such as: (Doctor, Registered Nurse, Physiotherapist or Occupational Therapist)

2. Name of Physician \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone \_\_\_\_\_

The eligibility of an applicant for Paratransit is directly dependent on his/her inability to **physically** use regular buses. It does not necessarily depend on other medical problems such as cardiovascular disease, pulmonary disease, general disability or old age but, they may be additional factors taken into consideration. **Please refer to the eligibility criteria on page 1.**

Please explain **(in detail)** the nature of disability, when it occurred and prognosis of same.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. Careful completion of this section will assist us greatly in processing the application. Please provide us with your comments.**

1. In your opinion, is the patient's disability:  
permanent \_\_\_\_\_ temporary \_\_\_\_\_ If temporary, expected duration? \_\_\_\_\_

2. Does the applicant have any difficulty with coordination in:  
upper extremities yes \_\_\_\_\_ no \_\_\_\_\_ lower extremities yes \_\_\_\_\_ no \_\_\_\_\_  
further comments \_\_\_\_\_

3. Please indicate what percentage the patient can flex and extend his/her:

Upper extremities: flex (L) \_\_\_ (R) \_\_\_ extend (L) \_\_\_ (R) \_\_\_  
Knees: flex (L) \_\_\_ (R) \_\_\_ extend (L) \_\_\_ (R) \_\_\_  
Hips: flex (L) \_\_\_ (R) \_\_\_ extend (L) \_\_\_ (R) \_\_\_

4. In your opinion, does this patient require an assistant to accompany him/her **while travelling**?  
yes \_\_\_\_\_ no \_\_\_\_\_

5. (i) Is the applicant able to climb and descend the three (3) steps used on regular buses?  
yes \_\_\_\_\_ no \_\_\_\_\_

(ii) Is the applicant able to walk 175 metres? yes \_\_\_\_\_ no \_\_\_\_\_

6. Additional comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

Please note: For safety reasons, if a passenger is using a three-wheeled, scooter-type mobility aid, they should transfer from the scooter to an ambulatory seat within the bus. However, service will not be denied to those passengers who are not able to transfer without risk of injury. Is this patient able to transfer to an ambulatory seat without risk of injury?

yes \_\_\_\_\_ no \_\_\_\_\_

| Office use only                 |             |            |
|---------------------------------|-------------|------------|
| Registration                    |             |            |
| Class                           | Regist. No. | Type       |
| Approval Date<br>Day Month Year |             | Disc. Code |

|                                   |
|-----------------------------------|
| For temporary<br>Registrants only |
| Expiry Date                       |
| Day Month Year                    |