Brandon Handi-Transit
PEOPLE MOVING PEOPLE

# Application for Handi Transit Service

If you have a disability that prevents you from using transit buses some or all of the time, you may be eligible for door-to-door handi transit services. An individual who is unable to use the regular transit system, due to a physical, cognitive or functional disability, may be eligible for handi services. Handi Transit is a shared ride, door-to-door service that operates within the City of Brandon limits. Drivers assist passengers from the exterior door of the pick up location to the exterior door of the destination location.

## Eligibility Criteria

Eligibility is granted based on a reflection of the client's real needs, which takes into account the client's ability or inability to use the regular, fixed route transit system. This is determined on the basis of information provided on the application form and, where necessary, through a personal interview. A person may qualify for handi transit service for the following reasons:

□ Requires the use of a wheelchair or scooter;

□ Inability to board a regular transit bus (with stairs);

□ Inability to walk one block or to the bus stop nearest their residence;

□ Insufficient endurance or stamina to ride a regular transit bus for a reasonable length of time;

□ Unable to utilize regular transit due to cognitive or physical disability;

***** Elderly and blind persons able to board public transit are not automatically eligible.**

## INSTRUCTIONS

1. Please complete the following form as directed. It is important that you understand the eligibility requirements, and that you complete all sections of the form correctly and in full.
2. Section 1, General Information, must be filled out by the applicant or by any other person designated by him or her or an authorized representative if the applicant is unable to act.
3. Section 2, Functional Assessment Form, must be completed and signed by a medical professional (see list of eligible certifications). All assessments must be authorized by the signature of such professional. Please be clear as to the applicant's ability/inability to use the regular transit system.
4. Please note that filling out this application form does not guarantee eligibility or approval.
5. There is no charge to apply for Handi Transit service. Any fees charged by a medical professional are the responsibility of the applicant.
6. Once received, the application will be reviewed and you will be contacted within 5 business days regarding the status of your application. In some cases, additional phone calls or an interview may be required to determine eligibility.
7. If you have any questions, you may call Handi Transit
8. Services at (204) 729-2437.
9. Completed forms may be faxed to (204) 729-2485, or mailed to:

**HANDI TRANSIT SERVICE**
**APPLICATIONS**
**900 RICHMOND AVENUE EAST**
**BRANDON, MANITOBA R7A 7M1**

# Section 1: General Information
**(Please print clearly)**

## APPLICANT INFORMATION

| LAST NAME | | FIRST NAME | |
|---|---|---|---|

| HOME ADDRESS | | | | BRANDON, MB | |
|---|---|---|---|---|---|
| | *( Apt)* | *(Number)* | *(Street)* | | *(Postal Code)* |

NAME OF LONG TERM CARE FACILITY (IF APPROPRIATE):

| Date of Birth | | | |
|---|---|---|---|
| | *( Day)* | *(Month)* | *(Year)* |

**Gender:** Female ☐ Male ☐

| HOME PHONE NUMBER: | | | | – | | | | |
|---|---|---|---|---|---|---|---|---|
| WORK PHONE NUMBER: | | | | – | | | | |
| ALTERNATE (CELL) NUMBER: | | | | – | | | | |

E-MAIL ADDRESS:

## EMERGENCY CONTACT

**List two people we can contact in case of an emergency (24 hours a day):**

NAME:

PHONE (HOME):

PHONE (WORK):

PHONE (MOBILE):

Relationship to applicant:

NAME:

PHONE (HOME):

PHONE (WORK):

PHONE (MOBILE):

Relationship to applicant:

**If there is no one at your residence to meet you and you cannot be left alone, you MUST provide an alternate address close by to drop you off at.**

CONTACT NAME:

Relationship to applicant:

ADDRESS:

PHONE:

ALTERNATE PHONE:

**All personal and personal health information collected is under the authority of The Freedom of Information and Protection of Privacy Act (FIPPA) and/or The Personal Health Information Act (PHIA) and is protected by the privacy provisions of said Act. All information provided in this form is confidential and solely for the use of Brandon Transit and its agents in determining eligibility for Handi Transit service as authorized by the City of Brandon.**

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## DISABILITY INFORMATION

1. Please describe your disability or medical condition.

_____

_____

2. How does your disability prevent you from using a regular transit bus?

_____

☐ ☐

_____

3. Is your disability: Permanent (life long) YES NO
   Temporary until: _____ (can be extended as required)

4. Does your disability include any of the following cognitive and/or physical mobility issues? (check all that apply and indicate any other factor you feel should be noted)

| | | | |
|---|---|---|---|
| Unable to walk three city blocks | ☐ | Unable to walk up or down steps | ☐ |
| Unable to stand for 15 minutes | ☐ | Unable to travel on buses due to fatigue | ☐ |
| Unable to sit or rise unassisted | ☐ | Shortness of breath due to exertion | ☐ |
| Unable to see signs or notices | ☐ | Unable to plan a trip and travel alone outside home | ☐ |
| Unable to travel unassisted due to confusion, or cognitive or organized limitation | | | ☐ |

Other (please specify): _____

## EQUIPMENT INFORMATION

5. Do you use any of the following to help you get around? (please check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| Power Wheelchair | ☐ | Cane | ☐ | Long Detection Cane (white) | ☐ |
| Manual Wheelchair | ☐ | Crutches | ☐ | Prosthetic/Orthotic Device | ☐ |
| Three Wheel Scooter | ☐ | Walker | ☐ | Portable Oxygen Tank | ☐ |
| Four Wheel Scooter | ☐ | Hearing Aid | ☐ | Communication Devices | ☐ |
| Collapsible Walker | ☐ | Service Animal | ☐ | Other:_____ | ☐ |

6. If you selected one of the wheelchairs above, please check the device that you will use most often when riding with Handi Transit services:

**POWER WHEELCHAIR** ☐ Standard ☐ Reclining ☐ Extended Foot Rests

**MANUAL WHEELCHAIR**

☐ Standard ☐ Reclining ☐ Extended Foot Rests ☐ Broda Chair

Please provide outside dimensions of your chair. Our wheelchair lifts measure 33” wide x 52” long (83cm x 132cm). Equipment larger than this cannot be accommodated.
**Please note: Combined weight of passenger & mobility aid must not exceed 750lbs.**
Width of Chair _____ Length of Chair _____

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## TRAVEL INFORMATION

7. When did you last use or tried to use a Brandon Transit Bus? _____
   Location of nearest City bus stop to your residence (Street location)_____
   How far is that bus stop from your residence ((Number of blocks) _____
   Are there any physical reasons or barriers to stop you from using the bus stop? (explain if answer is yes) _____

8. How are you currently getting around (travelling) in the community? Check all that apply.

- ☐ Own Car
- ☐ Regular Public Transit
- ☐ Taxi Cab
- ☐ Family/Friends drive
- ☐ Staff drive me
- ☐ Other (explain):

## ATTENDANTS

9. Attendant Required - Handi Transit Services may require an attendant to accompany a client for the safety and well being of the client and other passengers. Reasons for requiring an attendant include, but are not limited to, an unstable medical condition such as seizures and/or confusion, disorientation, anxiety, agitation, impaired or limited cognitive functioning and/or communication, and the inability to operate a wheelchair or motorized device independently.

   Do you believe that you require an attendant? Yes ☐ No ☐

   If the answer to the above question is yes, then please state the nature of the medical condition or special need which may require an attendant. (This question is asked to ensure your safety.)

   _____
   _____
   _____
   _____

## HOME ENVIRONMENT

10. Please check the most appropriate description of your pick up location.

- ☐ House/Mobile Home
- ☐ Apartment/Townhouse/
- ☐ Other (explain):
- ☐ Long Term Care Facility/Personal
- ☐ Hospital

11. Where is your pick up door:

☐ Front ☐ Side ☐ Back ☐ Garage ☐ Other (explain): _____

12. Does your home have steps outside at pick up door?

☐ NO ☐ YES If Yes, how many steps? _____

13. Do you need someone to help you go up or down these steps? ☐ YES ☐ NO

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Note: Drivers are only required to assist manual wheelchairs up 1 vertical step. For more than 1 step, you must make alternate arrangements (i.e. ramp).

## CERTIFICATION

I hereby declare that I have a disability that is sufficiently severe such that I am unable without assistance, to use transit buses some or all of the time. I consent to the disclosure of personal information (including medical information) by a medical professional, to Brandon Handi Transit or its agents for the purpose of determining my eligibility for Handi Transit Service. I will advise Brandon Handi Transit or its agents of any changes to my mobility needs. I understand that Brandon Handi Transit has the right to review my application from time to time and can revoke my registration if they determine that I am no longer eligible for handi service.

Name of your medical professional _____Telephone _____

- ☐ Physician
- ☐ Chiropractor
- ☐ Registered Nurse
- ☐ Physical Therapist
- ☐ Occupational Therapist
- ☐ Social Worker
- ☐ Certified Psychologist/
- ☐ Optometrist/
- ☐ Long Term Care Case

### A. APPLICANT SIGNATURE

*or*

### B. ADVOCATE OR SPOKESPERSON COMPLETING FORM FOR APPLICANT *(please check one)*

_____

Signature of Applicant

_____ Date

Please send completed application to:

**HANDI TRANSIT SERVICE**
**APPLICATIONS**
**900 RICHMOND AVENUE EAST**
**BRANDON, MANITOBA R7A 7M1**

○ I certify that the information provided in this application is true and correct, based upon information given to me by the applicant.

○ I certify that the information provided in this application is true and correct, based upon a designated service agency assessment of the applicant's health condition or disability, which restricts their use of regular transit service.†

†Designated agencies/representatives include: CNIB, Intermediate or Extended Care Facility Case Manager, Dementia/ Geriatric Program Case Managers, Mental Health Case Managers, Community Living Program Social Workers.

_____
Name

_____
Signature

_____
Facility or Program

_____
Relationship to Applicant

_____
Address

_____
Daytime Phone Number

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