1 Halton Hills Drive, Halton Hills, L7G 5G2
905-873-2601 | 1-877-712-2205
haltonhills.ca

# Application for Persons with a Disability

**Eligible Criteria**
Any persons with a physical, medical or cognitive disability is eligible to register as an ActiVan user. Please note that sections D, E and F of this application must be filled out and signed by a recognized medical practitioner.

**Application Instructions**
Applicants must complete sections A, B and C and have their health care professional complete sections D, E and F

## A. Personal Information

Name: ______________________________

Date of Birth: ______________ Age: ______________ Male ☐ Female ☐

Address: ______________ Apartment/Suite or Unit: ______________

City or Town: ______________ Postal Code: ______________

Home Telephone: ______________ Business Telephone: ______________

## B. Emergency Contacts

Please provide the names of two persons to be contacted in case of emergency. One must reside at a different address and phone number than the applicant and one must be next of kin.

Name: ______________________________

Address: ______________ Apartment/Suite or Unit: ______________

City or Town: ______________ Postal Code: ______________

Home Telephone: ______________ Business Telephone: ______________

Relationship to client: ______________________________

Name: ______________________________

Address: ______________ Apartment/Suite or Unit: ______________

City or Town: ______________ Postal Code: ______________

Home Telephone: ______________ Business Telephone: ______________

Relationship to client: ______________________________

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## C. Applicants Authorization

I hereby authorize the undersigned health care professional to release the information provided by them on this application for the purpose of determining my eligibility as a Town of Halton Hills ActiVan registrant. I also understand that my continued eligibility may be reassessed from time to time.

Applicants Signature ____________________ Date ____________________

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

## D. Health Professional Information

- ☐ CPSO (Physician)
- ☐ BDPT (Physiotherapist)
- ☐ BDC (Chiropractor)
- ☐ OSOT (Occ. Therapy)
- ☐ RN (Registered Nurse)

Other: ____________________

Name: ____________________

Address: ____________________ Suite or Unit: ____________________

City or Town: ____________________ Postal Code: ____________________

Telephone: ____________________ Fax: ____________________

## E. Disability Information

Diagnosis of physical disability:

____________________

____________________

____________________

List applicant's physical restrictions and how they affect his or her mobility:

____________________

____________________

# Application for Persons with a Disability

Is or does the applicant

1. Physically able to climb/descend stairs on a regular basis? Yes ☐ No ☐
2. Physically able to walk a distance of 175m (600ft. an average block)? Yes ☐ No ☐
3. Able to transfer from wheelchair to car with minimal assistance? Yes ☐ No ☐
4. Suffer from vertigo to the degree that he/she would fall? Yes ☐ No ☐
5. Cognitively impaired? If so, to what degree? Yes ☐ No ☐

   ______________________________________________________________________

6. Require an attendant or escort? Yes ☐ No ☐
   (i.e. is unable to self-direct own care and would be unable to be left safely unattended aboard the vehicle or while in transit)

**F. Does the Applicant Use Mobility Aids?**

Yes ☐ No ☐

If so, please indicate which ones:

☐ Wheelchair ☐ Electric Wheelchair ☐ Cane ☐ Scooter
☐ Walker Crutches ☐ Leg Braces

Other: ______________________________________________________________

Are there any other physical factors limiting the applicant's mobility? If yes, please explain.

______________________________________________________________________

______________________________________________________________________

For what time period are special transit services required?

☐ Temporary ☐ Permanent

Length of time: ______________________________________________________

Does the applicant live alone? Yes ☐ No ☐
Will the applicant make his/her own bookings? Yes ☐ No ☐
If no, is applicant aware of bookings made? Yes ☐ No ☐

# Application for Persons with a Disability

**I hereby certify that the information given above is correct**

Health Care Professional Signature ______________________ Date ______________________

**For Office Use Only**

Received by: ______________________ Date: ______________________

Registration Number Assigned: ______________________

The personal information on this form is collected under the authority of Section 11 of the Municipal Act, as amended. The information is used for the purpose of processing this application and administering the program. Questions regarding the collection of this information should be directed to the Town's ActiVan Transit Coordinator at 905-873-2601 ext. 2617 or activan@haltonhills.ca

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