

MobilityPLUS North Dumfries Application

Application Overview and Eligibility Mandate

Please note that the eligibility criteria and application process are different for residents of the urban service areas of Kitchener, Waterloo and Cambridge. Information on how to apply for service in the urban service areas is available at grt.ca/accessibility or by calling 519-585-7555.

GRT MobilityPLUS North Dumfries is a specialized transit service developed specifically for the residents of North Dumfries township.

GRT MobilityPLUS North Dumfries Service is intended for persons who:

- are 65 years of age or older or
- are registered with CNIB or
- have a physical challenge or
- have a cognitive challenge or
- have a temporary mobility impairment, such as a broken leg

Part A of the application may be completed by the applicant (you), or by someone on your behalf. The application will be reviewed to determine eligibility. A letter of acceptance or denial will be mailed to you. If you are accepted, an information package about GRT MobilityPLUS services will be included.

Completed applications will be reviewed within 14 calendar days from the day they are received. Please contact us at 519-585-7555 if you have not been contacted by GRT by the end of the 14-day period.

Disclaimer

All personal information collected on this application and any supporting documentation is collected under the authority of the Municipal Act, 2001, and in accordance with the Municipal Freedom of Information and Protection of Privacy Act, and is used solely for the purpose of determining eligibility for Grand River Transit specialized transit services. The application and supporting documentation will be discussed only with the applicant, the applicant's legal guardian, or appointed substitute decision-maker. If a Release of Information consent is completed, the application may be discussed with the individual named in the release. Any questions about this collection should be directed to the Manager, Marketing and Communications at 250 Strasburg Rd, Kitchener ON, 519-585-7555, TTY: 519-575-4608.

I have read and understood the above application overview.

Applicant or designate's name (please print)

Applicant or designate's signature

Part A: Applicant details

1. Contact information

_____	_____	_____	_____
Title	First name	Initial	Last name

Address			

_____	_____	_____	_____
City	Province	Postal code	

_____	_____		
Phone number	Email address		

Date of birth (DD/MM/YYYY)

2. I am applying for GRT MobilityPLUS North Dumfries because:

- a) I am 65 years of age or older
 - Yes Please provide proof of age documentation
 - No
- b) I am registered with CNIB
 - Yes Please provide proof of CNIB registration
 - No
- c) I have a physical challenge
 - Yes
 - No
- d) I have a cognitive challenge
 - Yes
 - No
- e) I have a temporary mobility impairment, such as a broken leg
 - Yes
 - No

3. Do you require physical assistance to transfer to, or sit in a four door car?

Yes

No

If Yes, please identify what type of assistance is required:

4. Do you require supervision?

Yes Please complete questions 4a-b

No

4a. Is the supervision due to

Lack of cognitive ability to recognize the destination

Confusion

Memory issues

Vulnerability

Behavioural challenges

Age

Other: _____

4b. Can you:

Be left alone at the accessible door of your destination? Yes No

Travel without a companion or attendant? Yes No

Remain unsupervised on-board the vehicle for one hour? Yes No

Identify the correct bus to board at a bus stop? Yes No

Please be aware that if you face any of the challenges as identified in Question 4, it is your and/or your family and/or caregiver's responsibility to provide any supports that are needed to request transportation, travel to, from or on-board the vehicle or access community resources.

GRT MobilityPLUS is an accessible door to accessible door transportation service. Some physical assistance is provided, such as pushing a person in a wheelchair from the vehicle to the accessible door. Please be aware that the vehicle operator will be absent from the vehicle while escorting other customers to their door. The vehicle operator will use the on-board restraint system to secure persons using a mobility aid.

Devices and mobility aids

5. Are you:

Using portable oxygen?

Yes No

Using a cane?

Yes No

Using crutches?

Yes Standard crutches Forearm crutches

No

Using a walker?

Yes Folding Non-folding

No

Using a CSA Standard Z604 - 95 approved transportation stroller for children with individualized seating requirements?

Yes No

Legally blind? (Attach a copy of your CNIB registration card)

Yes No

Using a guide or service animal? (Attach a copy of your service animal's certification)

Yes No

Using a scooter? (Must transfer independently to seat on vehicle)

Yes No

Using a wheelchair?

Yes Manual Power

No

Using a non-folding (or not easily folded) wheelchair?

Yes No

Using a chair that can be folded quickly under direction and put in trunk of vehicle?

Yes No

Please indicate make and model of manual and/or power wheelchair:

Using a chair with Broda specialized seating?

Yes No

Using a transport chair (4 small wheels)?

Yes No

Is your wheelchair wider than 31 inches (78 centimeters) from outer side wheel to outer side wheel?

Yes Provide width measurement: _____

No

Does the combined weight of person and mobility aid exceed 750 pounds (340 kg)?

Yes No

6. Please provide a brief summary of any information pertinent to this application:

I/we hereby certify that the information provided is accurate and complete to the best of my knowledge. I/We allow GRT to contact any healthcare professional or family member named within to obtain further information as required to determine eligibility status. Upon successful registration, I/we allow GRT to contact individuals named within to assist with operational concerns, should they arise.

Signature Name (please print) Date

Signature of witness Name of witness (please print) Date

Submitting this application

Ensure you have filled in all the blanks in all sections of the application. Incomplete applications cannot be processed. You may wish to make a copy for your own records.

If you are under 65 years of age and not registered with CNIB, have your health care professional complete Part B.

Return the complete application with copies of any necessary documentation to Grand River Transit.

Fax to: 519-744-2899

Scan and email to: grtinfo@regionofwaterloo.ca

Mail to: Grand River Transit, 250 Strasburg Rd, Kitchener ON N2E 3M6

Questions? Contact us at 519-585-7555 / TTY 519-585-4806

Part B: Mobility Assessment Form

The following Mobility Assessment Form must be completed by a Physician, Registered Nurse (RN), Physiotherapist or Occupational Therapist.

Please note: If you are a CNIB registrant or 65 or older, a Mobility Assessment is not required for your application. Please follow the submission instructions on the previous page and remember to include a photocopy of your CNIB registration card or a photocopy of your birth certificate or senior citizen's card.

1. Diagnosis of illness/disability: _____

2. Describe the impact of the illness/disability on the applicant's physical mobility:

3. Describe the impact of the illness/disability on the applicant's cognitive ability:

4. Is the applicant physically able to walk 175 meters?

Yes No

5. Is it expected that the applicant's physical mobility will improve?

Yes No

6. Please indicate the time period you recommend the applicant use specialized transit:

Temporary (Applicant's mobility is expected to improve)

Specify anticipated END date: _____

Permanent (Applicant's mobility is not expected to improve)

I have fully assessed the mobility restrictions of _____
(applicant's name) as relates to the GRT MobilityPLUS North Dumfries Eligibility Criteria and can affirm that the applicant:

has a physical challenge

has a temporary mobility impairment, such as a broken leg

has a cognitive challenge

Please check which professional designation pertains to you:

- Physician
- Registered Nurse
- Occupational Therapist
- Physiotherapist

Contact information

Health professional's name

Name of clinic/hospital/practice

Phone number

Fax number

Email address

Signature

Date (DD/MM/YYYY)