Application for Handi-Transit Service

What is Handi-Transit?

Handi-Transit is a special service which provides transportation for people who cannot use other modes of transport because of mobility impairment, age related impairment, age related frailty or are legally blind.

Handi-Transit is a shared ride, door-to-door service. Drivers physically assist passengers from the ground floor doorway, to and from the vehicle, to the ground floor doorway at the destination.

Instructions

Please complete the following form as directed. Forms that have insufficient information, are unclear, or illegible cannot be processed and will be returned by mail. We cannot be responsible for items lost in the mail.

1. Section A must be filled out by the applicant (or with assistance when required).

2. Section B must be filled out by one of the following qualified health care professionals who have full knowledge of your condition: Chiropractor, Occupational Therapist, Physician, Physiotherapist, or Registered Nurse. For individuals who are legally blind and do not have mobility impairment, note page 5.

3. Please note that filling out this application form does not guarantee eligibility.

4. There is no charge to apply for Handi-Transit service. Any fees charged by a qualified health care professional to complete this form are the responsibility of the applicant.

5. Once the application is received, you will be notified that the application will be reviewed and you will be contacted in ten (10) business days regarding the status of your application. In some cases, additional phone calls or an interview may be required to determine eligibility.

6. If you have any questions regarding the transportation service, please call Wheelchair Service of Manitoba at (204) 982-0799. If you have questions regarding the program administration, please contact the RM of East St. Paul at (204) 668-8112.

7. Completed forms may be faxed to (204) 668-1987, or mailed to:

   Handi-Transit Applications
   RM of East St. Paul
   Unit #1-3021 Bird's Hill Road
   East St. Paul, Manitoba R2E 1A7

   Ph: (204)668-8112

8. All applications are strictly private and kept confidential by the municipality and Wheelchair Services of Manitoba and shall not be disclosed to any third party.

This Section to be completed by Applicant

Section A: Application Information
(Please Print Clearly)

Name of Applicant:
Mr. [ ]; Ms. [ ]; Mrs. [ ]:_________________ _________________ _________________
(First) (Middle) (Last)

Address:
____
____
____

Phone Number: (____) _______________ (____) _______________ (____) _______________
(Home) (Cell) (Work)

Date of Birth: ______________ _____ __________
(Month) (Day) (Year)

Email Address:____

Are you a current or past user of Handi-Transit? [ ] Yes [ ] No
If yes, what is (was) your registration number? _________________ [ ] Don't know

In some cases more information may be required to determine eligibility. If additional information is required, whom do we contact?

[ ] You or [ ] Someone else (Example: spouse, guardian, etc).
If we need to contact someone else, please provide contact information below.

Name: ___________________________________ Relationship: _____________________

Phone Number: (____) ____________ (____) ____________ (____) ____________
(Home) (Cell) (Work)

Emergency Contact

In case of an emergency, please list someone living in East St. Paul, Winnipeg or the surrounding area that we can contact.

Name: ___________________________ Relationship: _____________________________
____

Address: ____

Phone Number: (____) ____________ (____) ____________ (____) ____________
(Home) (Cell) (Work)

Transportation Information

1. Why are you applying for Handi-Transit shared ride service?

____

____

2. What are the ways you get around now? (Please check all that apply)
[ ] Drive
[ ] Family/Friends drive me
[ ] Taxi
[ ] Private bus (Personal care home/Program bus)
[ ] Other (Please specify):_________________________

3. Do you require any of the following aids when going out? (Please check all that apply)
[ ] Hearing aid/Communication device
[ ] Portable oxygen/ventilator [ ] Service animal
[ ] Cane
[ ] Crutches
Walker-[ ] Folding [ ] Not folding [ ] With seat [ ] with skis [ ] 3 wheels [ ] 4 wheels
Manual wheelchair [ ] Folding [ ] Not Folding
[ ] Power wheelchair
[ ] 3 Wheeled power scooter [ ] 4 Wheeled power scooter
[ ] Other (Please specify): ___________________________

4. Do you use mobility aids to get around your home?
[ ] No
[ ] Yes
If yes, what kind do you use? ___________________________

5. To accommodate mobility aids in vehicles, please provide the following information;
a)Special features of aids (i.e. - elevated leg rests, tilt recline on wheelchair, etc.)

____

b) Model of wheelchair? _____________________
c) Width of wheelchair (from outside wheel to outside wheel):_________

Information for Handi-Transit Scheduling

Should your application be approved, the following information will be required to assist in trip scheduling. Please complete the following:

Home Environment

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

[ ] House/Mobile home
[ ] Apartment/Town house/Condo/Duplex
[ ] Long term care facility/Personal care home
[ ] Hospital
[ ] Other (Please specify): ________________________

2. Where is your pick up door?

[ ] Front
[ ] Side
[ ] Back
[ ] Other (Please specify): _________________________

3. Does your residence have steps outside the pickup door?

[ ] No
[ ] Yes
If yes, how many steps? ___________________________

4. Is there a handrail going up these steps?

[ ] No
[ ] Yes
If yes, what side are they on?
[ ] Right
[ ] Left

5. Do you need someone to help you go up or down these steps?

[ ] No
[ ] Yes

6. Does your residence have a ramp?

[ ] No
[ ] Yes
If yes, where is the ramp located? ______________________
Note: Drivers are only required to assist manual wheelchairs up or down three stairs.
For more than three stairs, or the use of an electric wheelchair, the registrant must make arrangements for alternative assistance (i.e., ramp).

THIS PAGE IS FOR INDIVIDUALS WHO ARE LEGALLY BLIND ONLY
(DO NOT HAVE A MOBILITY IMPAIRMENT)

CNIB Registrants Only:
Please provide CNIB registration number: __________________

I authorize CNIB to release my registration number to Wheelchair Service of Manitoba to confirm my registration.

Signature of Applicant or Representative _______________________Date:____________

For Applicants who are legally blind and are not clients of CNIB Verification must be provided an Optometrist or Ophthalmologist.
The applicant has a visual impairment of:
[ ] 20/200 vision or less
[ ] Visual field of less than 20 degrees (legally blind)

Additional comments:
____
____

Name: ______________________Title:__________________

Signature: ___________________ Date: _________________

Note: For applicants who are legally blind and do not have a mobility impairment, stop filling out this application and submit for processing.

Authorization for Release of Information: (To be completed by Applicant)

Please note that the personal information collected on this form is subject to the provisions of the Freedom of Information and Protection of Privacy Act and the Personal Health Information Act. The information will not be shared with anyone other than as set out in the consent below and will not be used for any purpose other than for determining eligibility for Handi-Transit Services.

I authorize the professional completing this form to release pertinent medical information to Wheelchair Service of Manitoba Handi-Transit Division, about my disability or health condition as it relates to determining my eligibility for specialized transportation.

Name of Applicant:_____________________________________ Date:__________________

Signature of Applicant/Legal Guardian: ____

Section B: To be completed by a health care professional

Professional Certification (Please check one):
[ ] Chiropractor [ ] Occupational Therapist [ ] Physician [ ] Physiotherapist [ ] Registered Nurse

Mobility Information: (Please print clearly)

1. Describe the medical diagnoses that compromise the applicant's mobility.

____
____

2. Describe the medical treatment plan, projected outcome and any ongoing care required regarding mobility.

____
____

3. Is the condition(s) permanent? [ ] Yes [ ] No
Is the condition(s) progressive? [ ] Yes [ ] No

4. The Applicants' mobility is affected by the following:

	N/A	Mild	Severe
Balance			
Endurance			
Pain			
Respiratory (SOB)			
Spasticity/Tone			
Strength			
ROM			
Hemiplegia/Paresis			

Comments:____

5. Applicant Height:________________[ ] m/cm______________[ ] feet inches
Applicant Weight: ________________ [ ] kgs________________[ ] lbs

If applicant is unable to walk, please check here [ ] and proceed to wheelchair information on this page. If applicant is able to walk, please complete section below.

Ambulation:
Note: The distance between two bus stops is approximately 175 m/575 ft.

1. The applicant is able to walk 175 m/575 ft outside unassisted;
[ ] At all times
[ ] Some of the time (i.e. in summer, by taking rests) [ ] None of the time
[ ] Temporarily unable
Comments: ____

2. The applicant is able to manage stairs independently (check all that apply);
[ ] At all times
[ ] With a person assisting
[ ] With a rail
[ ] None of the time
Comments: ____

3. The applicant requires the following mobility aid(s) (check all that apply);
[ ] None
[ ] Cane
[ ] Crutches
[ ] Walker
[ ] Bariatric (oversized) walker
[ ] Other (Please specify): ____

Wheelchairs

1. The applicant requires the use of a manual wheelchair (check all that apply); [ ] At all times
[ ] Some of the time (i.e. less than 4 hours/day)
[ ] For long distances only [ ] Bariatric (oversize)
[ ] To be transported in a vehicle
[ ] Temporary, until the following date: ________________________________

2. The applicant requires the use of power mobility([ ] wheelchair or [ ] scooter) (check all that apply);
[ ] At all times
[ ] Some of the time
[ ] For long distances only
[ ] Bariatric (oversize)
[ ] To be transported in a vehicle
[ ] Temporary, until the following date: ___________________________

Transfers

Is the applicant able to transfer independently form wheelchair/scooter to the seat of a car or van?
[ ] No
[ ] Yes

Drivers physically assist passengers from the ground floor doorway, to and fro the vehicle, to the ground floor doorway at the destination. Drivers do not ring buzzers/doorbells or search for passengers. Drivers <u>will not</u> provide personal attendant service/supervision during the trip, or place passengers into the hands of someone else at the destination point (i.e. wait for a caregiver to arrive).

Knowing this, does the applicant require a personal attendant (someone who must travel with the applicant to provide assistance during the trip or at the destination) while traveling with Handi-Transit?
[ ] No
[ ] Yes
[ ] Sometimes
Comments: ____

Given the information provided in this application, to what degree is Handi-Transit recommended;
[ ] Not at all
[ ] All of the time
[ ] In winter only
[ ] For trips to and from dialysis treatment only
[ ] Some of the time (please specify):_________________________

[ ] Temporarily (Please specify): _____________________________
Note: Handi-Transit can accommodate individuals who are ambulatory or travel in a wheelchair/scooter. As part of the public transit system, we are unable to accommodate specific vehicle type of seating location preferences.

Additional comments:

____

____

____

Professional Verification (Please print)

I certify that I am currently an accredited/licensed practionior and that the information contained herein is accurate and complete.

Name:_____________________________________ Title: _______________________

Phone: (   )___________________

Address: ___________________________________ Email: ________________

Signature: __________________________________ Date: ______________

Personal Privacy: The personal information collected on this form is subject to the provisions of the Freedom of Information and Protection of Privacy Act (FIPPA) and the Personal Health Information Act (PHIA). The information will not be shared with anyone other than as set out in the previous consent above and will not be used for any purpose other than for determining eligibility for Handi-Transit Services. If you have any questions you may call Handi-Transit at (204) _______________.

Please return completed form to applicant