



Community Services Department

## Parallel Transit Application Form

We provide service for Stratford residents unable to access Stratford Transit. This service can be used for medical appointments, therapy, education, employment, shopping and social activities.

### Eligibility Criteria

1. Parallel Transit is a shared ride service for individuals who are unable to access Stratford Transit. It is intended for persons who are:
  - a. Physically unable to use Stratford Transit
  - b. Physically unable to walk a distance of 175 metres
  - c. Have temporary mobility impairment (i.e. broken leg)
  - d. Physically unable to walk 175 metres during winter months
2. We provide accessible door to accessible door service with lift-equipped busses. Drivers are not allowed to go into your residence and assist you.
3. The information used in this application process will be used by Parallel Transit only to assess the applicant's eligibility for specialized transit services.
4. The completed application will be assessed by Parallel Transit's Staff.

### Completion of Form

Forms may be obtained through the Parallel Transit Office, or a Parallel Transit Driver.

Parallel Transit reserves the right to review individual applications and request individuals to be reassessed if the need arises. This may include a physiotherapy assessment.

Parallel Transit is not responsible for any cost associated with the completion of this form.

For applicants whose original application has been denied, an outside assessment may be obtained with all costs being incurred by the applicant.

Completed applications can be given to a driver, faxed to 519-271-6029, mailed or dropped off at 60 Corcoran Street, Stratford, Ontario N5A 1V7.

This application is to be filled out by the person applying to use the bus or designate.

Please complete and return pages 2 & 3 of the enclosed forms. Page 4 must be completed by a Health Care Professional and returned to the above address. If you need assistance completing these forms please call 519-271-4000 Monday to Friday 8:00am – 7:00pm.

**Please Print**

Applicant Name: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ TTY #: \_\_\_\_\_

Is the applicant a minor? Yes/No **All minors must be accompanied by an adult.**

- 1. Can the applicant access Stratford Transit? Yes/No
- 2. Can the applicant walk 175 metres (575 feet)? Yes/No
- 3. If it is difficult to use Stratford Transit explain why:

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

- 4. Can the applicant travel on his/her own without an assistant or aide? Yes/No

If no, please give a brief explanation:

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

5. Please check boxes that pertain to the applicant:

Description	Yes	No
Uses portable oxygen		
Uses a cane		
Using crutches		
Uses a folding walker		
Uses a non-folding walker		
Temporary disability (i.e broken leg)		
Uses manual wheelchair		
Uses a power wheelchair		
Uses a scooter (must be able to transfer independently to a seat on the bus)		
Uses an oversized wheelchair (greater than 31" wide)* *If greater than 31" from outside wheel to outside wheel, please indicate all dimensions:		
Legally blind (uses service dog/white cane)		
Other (please describe):		

6. If you use a wheelchair is your residence ramped? Yes/No

If no, state accessibility \_\_\_\_\_  
\_\_\_\_\_

7. Contact name and address and phone number in case of an emergency:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

If you are not the applicant but have completed this form on the applicant's behalf, please provide the following information:

Your Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Daytime Phone #: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

I certify that to the best of my knowledge the above information is correct.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **Notice of Collection**

Personal information collected on these forms is collected under the authority of the Municipal Act, 2001 and will be used by the City of Stratford staff for the purpose of determining eligibility for Parallel Transit Services. Questions regarding the collection of this information may be directed to the City Clerk, P.O. Box 818, Stratford, ON, N5A 6W1 or by telephone 519-271-0250 ext. 235 during business hours.

## **Alternate Formats**

If you require this form in an alternate format, contact Community Services at 519-271-0250 ext. 264 or TTY at 519-271-5241.

# Parallel Transit Application

**\*To be completed by a Health Care Professional\***

You are being asked by the applicant (name) \_\_\_\_\_  
to provide information regarding his/her need to use Parallel Transit.

## 1. Eligibility Criteria

( ) is physically unable to access a Stratford Transit bus

( ) is physically unable to walk a distance of 175 metres

Relevant Medical/Surgical Condition \_\_\_\_\_  
\_\_\_\_\_

## 2. Will the applicant's medical condition improve?

( ) 1 to 3 months

( ) 4 to 8 months

( ) 9 to 12 months

( ) 18 months

( ) 2 years

( ) Not yet determined

( ) Not at all

## 3. Does the applicant need transportation for the winter months only?

(Please circle appropriate response) Yes No

## Health Care Professional Information:

Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Completion: \_\_\_\_\_

## Appeal Process

Should the applicant wish to appeal the decision made by Stratford Parallel Transit, they may do so. The appeal will be reviewed by the City of Stratford Parallel Transit Eligibility Review Panel. Appeals will be reviewed and a decision communicated to the Appellant within 30 days of the receipt of a request for appeal by the Administrative Assistant of the Director of Community Services.

The Panel decides, based on the available information, whether the Appellant is or is not eligible to use Stratford Parallel Transit, and, if eligible, any conditions that may be attached to that eligibility. Conditions may include validity only on days when ice and snow are present, or the requirement that the Appellant must be accompanied by an attendant when using Stratford Parallel Transit.

Decisions of the Panel are final.

## Parallel Transit Office Use Only

Date application mailed: \_\_\_\_\_

Date application returned: \_\_\_\_\_

### Approval:

Type: (Please circle)    Unconditional        Temporary        Conditional

Date approved: \_\_\_\_\_ Approved by: \_\_\_\_\_

Reassessment required?\* (Please circle)    Yes    No

Reassessment Date (if applicable): \_\_\_\_\_

### Declined:

Date declined: \_\_\_\_\_ Staff Signature: \_\_\_\_\_

Reason: \_\_\_\_\_

\_\_\_\_\_

Date ineligible letter mailed: \_\_\_\_\_

\*Unconditional approval does not require a reassessment.