CITY OF BROOKS HANDIBUS APPLICATION FORM

APPLICANT INFORMATION		
Name (full):		Gender:
Date of birth:		Phone:
Current address:		
City:	Province:	Postal Code:
EMERGENCY CONTACT		
Name:		
Address:		Phone:
City:	Province:	Alt Phone:
Relationship to Applicant:		Postal Code:
ALTERNATE EMERGENCY CONTACT		
Name:		
Address:		Phone:
City:	Province:	Alt Phone:
Relationship to Applicant:		Postal Code:

MEDICAL INFORMATION	
Doctor's Name:	Phone:
Address:	Fax:

Please have a medical practitioner complete the Handibus Medical Application Form and attach it to this application.

CLIENT QUESTIONAIRE

How often will you be utilizing the Handibus?

Recurring Booking: Yes: _____ No: ______ Occasionally: Yes: ____ No: ____ Rarely: Yes: ____ No: ____

What mobility aides do you use when travelling in the community? Please check all that apply. Your answers will ensure the appropriate specialized service will be provided.

☐ None	☐ Cane
☐ Walker- non-collapsible	☐ Walker-Collapsible
☐ Manual Wheelchair	☐ Electric Wheelchair
☐ Scooter	☐ Service Animal
☐ Oxygen	☐ Other:_______________

Please Note: If a wheelchair or scooter is used, the maximum base dimensions are 30″ x 50″ (76x127cm). Equipment larger than this cannot be accommodated. A combined weight of the equipment and the passenger cannot exceed 750lbs (340kg).

Does the outside dimensions of the wheelchair/scooter exceed these measurements? Yes:___________ No:___________
Does the combined weight of the passenger and mobility device exceed this weight? Yes:___________ No:___________
If yes to either, please explain:____

____

____.

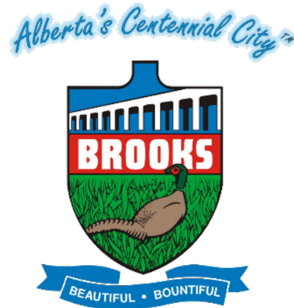
Can you recognize landmarks? Yes: _____ No: _____. If NO, please explain:____

____

____.

CITY OF BROOKS HANDIBUS APPLICATION FORM

<table>
<tr><th colspan="3">CLIENT QUESTIONAIRE CONTINUED</th></tr>
<tr><td colspan="3">Will you require a mandatory attendant when using the Handibus? Yes: _____ No: _____.</td></tr>
<tr><td colspan="3">Will your home address be your primary pick up point? Yes: _____ No: _____. If NO please provide your alternate address below, so we may add it to our files.</td></tr>
<tr><td colspan="2">Address:</td><td>Phone:</td></tr>
<tr><td>City:</td><td>Province:</td><td>Postal Code:</td></tr>
<tr><th colspan="3">AUTHORITY</th></tr>
<tr><td colspan="3">I HEREBY CERTIFY THAT I HAVE REVIEWED THE INFORMATION PROVIDED AND CERTIFY IT TO BE TRUE. I GIVE PERMISSION FOR THE CITY OF BROOKS HANDIBUS TO CONTACT MY AUTHENTICATOR TO VERIFY THE NEED FOR MY REQUEST.</td></tr>
<tr><td colspan="2">Signature of applicant:</td><td>Date:</td></tr>
<tr><td colspan="3">If someone else has completed this form on behalf of the applicant, please provide the following:</td></tr>
<tr><td>Name:</td><td colspan="2">Relationship to Applicant:</td></tr>
<tr><td colspan="2">Signature</td><td>Date:</td></tr>
</table>



This information is being collected for the purpose of establishing and operating the City's Handibus program pursuant to Section 33 (C) of the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection you may contact the City of Brooks FOIP Coordinator at 403-362-3333.

Handibus Application Form - Medical

To Be Completed By The Health Care Professional

PLEASE PRINT CLEARLY

City of Brooks Handibus is a door-to-door, shared-ride, driver-assisted transportation service for residents of Brooks, that are Seniors 65 and over, individuals with a physical or cognitive disability and for individuals with temporary disabilities on a temporary basis.

In order to ensure that Handibus resources are properly and effectively dedicated to the individuals it is intended to serve, it is necessary that applicants are carefully assessed to ensure that they are not able to utilize regular fixed-route transit.

For assistance or questions regarding eligibility, please call the City of Brooks Handibus at (403)362-3333.

Any charges for completing this form or for obtaining additional information are the responsibility of the applicant. Completion of this assessment does not guarantee eligibility.

Please be certain to base your evaluation solely upon the applicant's ability to use regular fully-accessible fixed-route transit.

Applicant's Name ____

Last First Middle

1. I have read Part A in its entirety. ☐ Yes ☐ No
2. I agree with the information provided in Part A. ☐ Yes ☐ No If you answered **NO** to either question(s), please explain:
3. What is the health condition(s) or disability that prevents the applicant from using the regular transit system?
4. Severity of disability/limitations: ☐Mild ☐Moderate ☐Severe ☐Profound
5. Expected duration of disability: ☐Temporary - Expected duration until ____/____/____
   YYYY MM DD
   ☐Permanent - No expectation of improvement
   ☐Seasonal - Use of regular transit impacted by winter ice and snow conditions (Approx. Oct. - Apr.)

6. Does the applicant require an attendant when riding the Handibus? ☐ Yes ☐ No

Handibus drivers must concentrate on the safe operation of their vehicles and cannot supervise those who require constant and frequent attention for medical or behavioral reasons. Registrants requiring attention of this nature, or who display behavior unacceptable to other passengers, will be required to ride with an attendant at all times. If the applicant requires a mandatory attendant, Handibus will only provide service when an attendant travels with the applicant at all times.

7. Can the applicant be left alone at his/her destination? ☐ Yes ☐ No

8. Can the applicant be left alone at home? ☐ Yes ☐ No

9. Are there any additional health concerns (i.e. behavioural, aggression, seizure) that the City of Brooks Handibus should be made aware of?

I hereby certify that the information included in this assessment is accurate and a true reflection of the applicant's ability to use regular fixed-route public transit.

Signature

Date _______/_______/_______
YYYY MM DD

Address ____
Unit and Bldg. No. Street

____
City Prov. Postal Code

Phone (_______) ____________________ License/Certification No: __________.

Professional designation:
☐ Licensed Physical Therapist ☐ Nurse
☐ Certified Rehabilitation Specialist ☐ Licensed Optometrist
☐ Registered Occupational Therapist ☐ Certified Psychologist
☐ Other:________________________________

With permission from the applicant, the Health Care Professional who verifies this form can also forward this completed application to: City of Brooks Handibus Registration, 201-1st Avenue West | Brooks AB T1R 1B7; or fax to (403) 362-4787.