

Kingston Access Bus Application Form

Please complete this form then submit it by:

- a. Fax: 613-549-6318
- b. Mail: PO Box 424
Kingston, ON K7L 4W2
- c. Bring it to the Kingston Access Bus office at 751 Dalton Ave.

It will help speed the processing of your application if you follow these instructions carefully. If further assistance is required to complete this form, please telephone 613-542- 2512.

A. ELIGIBILITY CRITERIA:

- 1. Kingston Access Bus is a service for individuals with physical disabilities regardless of age who, due to a mobility impairment, are unable to use conventional transit facilities.
- 2. Individuals who are elderly, blind, or who have emotional problems, epilepsy, and/or mental disabilities may be eligible for our service ONLY IF, in addition to the above, they have a PHYSICAL DISABILITY which prevents them from using a public transit vehicle.

B. COMPLETION OF APPLICATION FORM:

- 1. Fill out all parts of the form which apply to you.
- 2. If you do NOT use a wheelchair, you will be required to have a mobility assessment after a referral by your physician (see part 2 of online form)

C. PHYSICIAN'S REFERRAL FOR MOBILITY ASSESSMENT

- 1. Fill out all parts of the form which apply to you.
- 2. Have mobility assessment done at 751 Dalton Ave.

Name

First

Last

Address

No.

Street Name

Apt

City

Province

Postal Code

Residence Name (if appropriate): _____

Phone

Home _____ Alternate _____ ext. _____

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Email: _____

Eligibility Details

Is your disability? Permanent Temporary

If temporary, approximately how long? _____

Do you use a wheelchair? Yes No

If yes, is it? Standard Electric

Is your residence ramped? Yes No

If no, state accessibility: _____

If you do not use a wheelchair, do you walk with an assistive device? Yes No

If yes, please specify the type used: _____

Do you travel with a companion? Yes No

Name of person to contact in an emergency

Name: _____

Phone Number: _____

I HEREBY AUTHORIZE THE KINGSTON ACCESS BUS TO DETERMINE MY ELIGIBILITY AND IF DEEMED NECESSARY, TO CONSULT MY PERSONAL PHYSICIAN

Name

Date

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1. Can this passenger travel on their own without an assistant or aide?

Yes No

If "NO" please give a brief explanation _____

2. Can this passenger be safely left alone at their drop-off location without being placed in the care of another person?

Yes No

If "NO" please give a brief explanation _____

3. If the answer to question 2 is NO, please provide names, addresses and phone numbers of 2 other responsible persons who will receive this passenger in the event that no one is available at the home or the drop-off location.

First Choice

Name: _____

Address: _____

Home Phone: _____ Alternate Phone: _____ ext. _____

Second Choice

Name: _____

Address: _____

Home Phone: _____ Alternate Phone: _____ ext. _____

Please add any other comments or information that you feel will be helpful.

