

# Application for Custom Transit Service

handyDART and handyPASS Programs

If you have a disability that prevents you from using transit buses some or all of the time, you may be eligible for door-to-door custom transit services.

To avoid delay in processing your application, please complete all sections of the following form. Our staff will contact you to discuss your application and assist you regarding your travel options. BC Transit and its agents hold all information in confidence.

Pursuant to Section 27 (2) of the Freedom of Information and Protection of Privacy Act, information provided in this form is solely for the use of BC Transit and its agents in determining eligibility for Custom Transit Programs as authorized in the BC Transit Act.

If you have any questions, please call 250-339-5442 and ask for Client Registration.

NOTE: If your application for handyDART is denied, you may appeal this decision. Please call 250-339-5442 for more information.



## Part 1 - General Information

PLEASE PRINT

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Apt.# \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Intercom number \_\_\_\_\_ Telephone \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth \_\_\_\_\_

MONTH / DAY / YEAR

Female

Male

Please provide the following information:

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Can you be left alone at your residence? YES  NO

If no, please explain: \_\_\_\_\_

NOTE: If no, the person you have identified as the emergency contact will be called in the event no one is available to receive you or in case of an emergency.

---

Where should future correspondence be sent? To my home address  or to:

Name \_\_\_\_\_

Address \_\_\_\_\_

## Part 2 - Disability Information

1. What disability prevents you from using the regular transit bus?

---

2. Does your disability include any of the following cognitive and/or physical mobility issues?  
(check all that apply and indicate any other factor you feel should be noted)

- |  |                          |   |                          |
|--|--------------------------|---|--------------------------|
| Unable to walk three city blocks   | <input type="checkbox"/> | Unable to walk up and down steps                    | <input type="checkbox"/> |
| Unable to stand for 15 minutes   | <input type="checkbox"/> | Unable to travel on buses due to fatigue            | <input type="checkbox"/> |
| Unable to sit or rise unassisted   | <input type="checkbox"/> | Shortness of breath due to exertion                 | <input type="checkbox"/> |
| Unable to see signs or notices   | <input type="checkbox"/> | Unable to plan a trip and travel alone outside home | <input type="checkbox"/> |
| Unable to travel unassisted due to confusion, or cognitive or organizational limitations |                          |   | <input type="checkbox"/> |

Other \_\_\_\_\_

3. Is your disability: Permanent (life long) Yes  No   
Temporary until: \_\_\_\_\_ (can be extended as required)

4. Do you use any of the following to help you get around? (please check all that apply)

- |                     |                          |                |                          |                            |                          |
|---------------------|--------------------------|----------------|--------------------------|----------------------------|--------------------------|
| power wheelchair    | <input type="checkbox"/> | cane           | <input type="checkbox"/> | white cane                 | <input type="checkbox"/> |
| manual wheelchair   | <input type="checkbox"/> | crutches       | <input type="checkbox"/> | prosthetic/orthotic device | <input type="checkbox"/> |
| three-wheel scooter | <input type="checkbox"/> | walker         | <input type="checkbox"/> | portable oxygen tank       | <input type="checkbox"/> |
| four-wheel scooter  | <input type="checkbox"/> | service animal | <input type="checkbox"/> | other                      | _____                    |

5. Do you require a personal assistant to assist you to travel? Yes  No

6. Do you presently use the regular transit system for some of your trips?

Yes  How many days per month? \_\_\_\_\_

No  I don't ride because \_\_\_\_\_

7. Could you benefit from Community Travel Training which could enable you to use regular transit buses some of the time? Yes  No

8. Are you interested in a handyPASS, which is required to purchase Taxi Saver coupons and for your attendant to travel free on regular transit buses? Yes  No   
If Yes, a representative will contact to you to arrange for the card.

## Part 3 - Certification

I hereby declare that I have a disability that is sufficiently severe that I am unable without assistance to use transit buses some or all of the time, in accordance with Section 11, BC Transit Regulation 30/91, pursuant to the BC Transit Act. I consent to the disclosure of personal information (including medical information) by a medical practitioner, to BC Transit or its agents for the purpose of determining my eligibility for the custom transit service. I will advise BC Transit or its agents of any changes to my mobility needs. I understand that BC Transit has the right to review my application from time to time and can revoke my registration if they determine that I am no longer eligible for custom transit service.

Name of your medical practitioner \_\_\_\_\_ Telephone: \_\_\_\_\_

Physician

Occupational therapist

Physiotherapist

Registered nurse

Social worker

Long Term Care case manager

### A Applicant Signature

or

### B Advocate or spokesperson completing form for applicant. (Please check one):

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**Please send completed application to:**

**Comox Valley handyDART  
PO Box 100  
Lazo, BC  
V0R 2K0**

I certify that the information provided in this application is true and correct, based upon information given to me by the applicant.

I certify that the information provided in this application is true and correct, based upon a designated service agency assessment of the applicant's health condition or disability, which restricts their use of regular transit service.\*

\*Designated agencies/representatives include:  
CNIB, Intermediate or Extended Care Facility Case Manager, Dementia/Geriatric Program Case Managers, Mental Health Case Managers, Community Living Program Social Workers.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Facility or Program

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

\_\_\_\_\_  
Address

\_\_\_\_\_  
Daytime Phone