Admission Criteria

A. Be a person with a disability, meaning "any person with an impairment resulting in a significant and persistent disability and who is likely to encounter barriers in carrying out daily activities."
B. Have mobility limitations that justify the use of an adapted transportation service.

Therefore, any **temporary limitation** (for example: a broken leg) cannot be the subject of an admission request. You may consult the *Eligibility Policy for Adapted Transportation* on the Ministry of Transport's website at www.mtq.gouv.ca under the section *Persons with Disabilities*.

2. Procedure

A. Part 1: to be completed by the applicant.
B. Part 2: to be completed by a health care professional or a school network professional who has access to the applicant's diagnosis.

Motor or Organic Impairment:

For individuals who use a wheelchair permanently: Physician, occupational therapist, physiotherapist, physiatrist, or physical rehabilitation therapist.

In all other cases: Occupational therapist, physiotherapist, physiatrist, or physical rehabilitation therapist who has access to the applicant's diagnosis.

Intellectual Disability:

Specialized educator, psychoeducator, psychologist, or social worker (if not registered in a CRDI)

Visual Impairment:

Orientation and mobility specialist.

Psychiatric Impairment:

Occupational therapist, nurse, or social worker, all working in the field of psychiatric disability

The adapted transportation service of **TAP** reminds you that it is your responsibility to keep your medical information and personal information up to date so that we can carry out our work in your best interest.

Transports Québec

Application for Paratransit Eligibility

Cliquer sur le champ à droite
pour insérer une image

1 Eligibility Criteria

A. **Be a handicapped person, that is, "a person with a deficiency causing a significant and persistent disability (impairment), who is liable to encounter barriers in performing everyday activities."**

B. **Have mobility limitations that justify the use of paratransit services.**

Accordingly, a temporary limitation (for example, a broken leg) cannot qualify a person for paratransit eligibility.

You can access the *Paratransit Eligibility Policy* on the website of the ministère des Transports at www.mtq.gouv.qc.ca under the heading "Persons with disabilities".

2 Steps

A. **Part 1:** **To be filled out by the applicant.**

B. **Part 2:** **To be completed by a professional of the health care or education networks who has access to the diagnosis of the applicant's condition.**

Examples:
a cardiologist, a lung specialist or a neurologist;
an occupational therapist, a physical therapist or a physiatrist;
a physical rehabilitation therapist;
an optometrist or an ophthalmologist;
a visual impairment rehabilitation specialist;
a spatial orientation and mobility specialist;
a psychologist, a psychoeducator or a psychiatrist;
a special education technician;
a social worker;
a general practitioner (family medicine);
a nurse.

C. **Send your completed application along with a recent photograph and proof of your age[1] (photocopy of your birth certificate, passport, health insurance card or driver's licence) to the following address:**

[1] Proof of age is required in the case of accompaniment services for parental duties, free services for young children and reduced rates for students and persons aged 65 and over.

NO OTHER FORM MAY BE USED TO MAKE A VALID APPLICATION FOR PARATRANSIT ELIGIBILITY.

Ministère des Transports

V-2851A (2015-03)

Transports Québec

Application for Paratransit Eligibility

To be filled out by the eligibility officer			
File number			
Date of receipt of the application	Year	Month	Day

Part 1 - General Information

An application is to be completed by the applicant, by a person designated by the applicant or by the applicant's legal representative, where the applicant is unable to act. **Any incomplete or illegible application will be returned to the applicant, which delays processing of the application.** The confidentiality of the information conveyed will be maintained under the *Act respecting Access to documents held by public bodies and the Protection of personal information*. The information on the application is for the sole use of the eligibility committee.

SECTION 1
Information on the applicant

PRINT (REQUIRED)

Family name				First name		
Family name at birth (if different)						
Home address	No.	Street			Apt. No.	
Municipality					Postal Code	
Name of residential facility (if applicable)					Room No.	
Telephone Home	Area code / Number		Work	Area code / Number	Extension	
Cell	Area code / Number		Fax	Area code / Number		
Email address						
I agree to receive information or offers from my paratransit service provider ☐ Yes ☐ No						
Date of birth	Year / Month / Day		Gender ☐ Female ☐ Male		Weight	Height
Language spoken ☐ French ☐ English ☐ Other, specify: _____				Other means of communication Specify: _____		

SECTION 2
Questions relating to paratransit eligibility and to the type of accompaniment.

1 **Why are you applying for paratransit eligibility?**

_____

_____

_____

2 **Is there regular public transit service in your municipality?**

☐ No ☐ Yes ► If **yes**, are you able to use it?

☐ No ► State the reasons for that inability. _____

_____

_____

☐ Yes

☐ Do not know

3 **If you are declared eligible for paratransit, will you need the help of someone on board the vehicle (example: for repositioning) during your trip?**

☐ No ☐ Yes ► If **yes**, what kind of assistance? _____

_____

4 **A. If you are declared eligible for paratransit, will you require the use of mobility aids during your trips on paratransit?**

☐ No ☐ Yes

B. Specify the aid(s) required.

☐ Walker ► ☐ folding ☐ non-folding

☐ Rolling walker

☐ Cane ► Specify the type: _____

_____

☐ Crutches

☐ Guide dog or assistance dog (certified by a recognized school)

☐ Three-wheeled scooter or four-wheeled scooter

☐ Wheelchair ► ☐ motorized ☐ manual (rigid) ☐ manual (folding)

☐ Other ► Specify: _____

_____

C. Specify the aid that you will most frequently use:

_____

_____

D. Do you require bottled oxygen during your trips on paratransit?

☐ No ☐ Yes

5 **Do you have dependent children under the age of 14?**

☐ No ☐ Yes ► State the name and date of birth of each.

Family name	First name	Date of birth (Year / Month / Day)

Ministère des Transports

V-2851A (2015-03)

Adapted Transportation Service – 819-648-2223
1226A Route 148, Campbell's Bay, QC J0X 1K0

SECTION 3
References and signature

1 **Is there a professional other than the one completing the attestation of disability (Part 2 of the form) the eligibility committee could reach, if necessary, to facilitate the study of your application?**

Family name | First name

Position | Name of facility (if any)

Telephone Area code | Number | Extension | Prof. licence No. (if any)

2 **If the applicant is not the person completing this Part, give the name of the person who does so on his or her behalf.**

Family name | First name

Telephone
Home: Area code | Number
Work: Area code | Number | Extension
Cell: Area code | Number
Relationship to applicant

Name of facility (if any)

3 **Person to contact in case of emergency.**

Family name | First name

Telephone
Home: Area code | Number
Work: Area code | Number | Extension
Cell: Area code | Number
Relationship to applicant

Name of facility (if any)

Applicant's authorization

I certify that the information provided is accurate. I understand that a false statement could lead to the rejection of my eligibility application or the withdrawal of my paratransit eligibility. I hereby consent to have the eligibility committee review all the information provided on this form and in any supporting documents. I also authorize the committee to contact any person indicated in Question 1 of this Section, and the persons completing Part 2 of the form or any other attestation submitted with the application, for the purpose of validating the information conveyed or for obtaining further information, as required. I understand that, if I am declared eligible, only the information necessary for my travel, my safety and my comfort will be disclosed to paratransit service providers.

Signature required

Applicant's signature	Signature of representative on behalf of applicant unable to act	Date (YYYY-MM-DD)

You may append additional information in support of your eligibility or your paratransit needs.

Part 2 - Attestation of Disability (to be completed by a professional)

Please ensure that this part is properly filled out, otherwise processing of the application and access to paratransit service will be delayed.

1 A. What is the principal diagnosis on the applicant's record wich causes mobility limitations?

Since when? _____

Check off and specify, if appropriate, the medical classification of the diagnosis in terms of functional impairment (level, class, stage):

- ☐ Intellectual disability ► level (mild, moderate, severe, profound) _____
- ☐ Respiratory deficiency ► class _____ / V
- ☐ Cardiac deficiency (New York Heart Association) ► class _____ / IV
- ☐ Parkinson's disease (Hoehn and Yahr Scale) ► stage _____ / V
- ☐ Traumatic brain injury ► level (mild, moderate, severe) _____
- ☐ Alzheimer's disease (Reisberg's Scale or Global Deterioration Scale [DAT]) ► stage _____ / 7
- ☐ Other ► Specify: _____

B. Indicate any other diagnosis related to the need for paratransit service.

_____

2 Does the applicant's condition allow foreseeing a possible recovery?

- ☐ No ► Explain: _____
- ☐ Yes ► Indicate the timeframe and explain: ☐ within a year _____
  ☐ longer than a year _____

3 Does the applicant have one of the disabilities described below?

- ☐ No ► Go to Question 11.
- ☐ Yes ► Check off the applicant's limitations in one or more areas (eligibility criteria).
  - ☐ **1.** Walk 400 metres on even ground.
  - ☐ **2.** Climb a step 35 cm high with support or descend without support.
  - ☐ **3.** Make an entire trip using public transit because of extreme susceptibility to fatigue.
  - ☐ **4.** Keep track of time.
  - ☐ **5.** Find one's bearings.
  - ☐ **6.** Master situations or behaviour that could compromise one's own safety or that of others.
  - ☐ **7.** Communicate orally or through sign language. N.B.: this limitation alone cannot qualify the applicant for paratransit eligibility.

4 When do the disabilities indicated in Question 3 become apparent (if there is more than one disability, please write down the corresponding numbers from Question 3 in the appropriate boxes)?

- ☐ Throughout the year ☐ Only in winter ☐ Only after dusk
- ☐ Only when the applicant faces certain geographic obstacles. ► Specify: _____
- ☐ Only when the applicant travels with a dependent child under the age of 6.
- ☐ When the trip is unfamiliar, overly complex or involves a dangerous intersection.
- ☐ Only when the applicant travels for hemodialysis.
- ☐ In certain situations or intermittently ► Specify: _____

5 **Questions that are specific to certain impairments or disabilities: *answer only those that are relevant.***

A. Motor, neurological or internal organ impairment

Specify, where appropriate, the type of functional assessment conducted and the result:

Berg scale (balance) _____

Other ▶ Specify: _____

1) Ability to walk on even ground (specify)

A) Maximum distance (in metres) that the person can cover _____

B) Time required to cover the distance _____

C) Condition of the person after walking this distance _____

2) Ability to climb a step with support or descend without support (specify)

A) Height of step the person can climb with support _____

B) Height the person can descend from without support _____

C) Limitation observed: range, muscular weakness, pain, balance _____

_____

3) Ability to take regular transit for a round trip

A) At any time ▶ Explain: _____

B) Intermittently ▶ Explain: _____

B. Visual deficiency (check off and specify)

Visual acuity:

Far-sight vision with prescription lens (in metrics):

RE _____ LE _____ Both eyes _____

Visual field:

Under 20° ▶ ☐ RE _____ ☐ LE _____

Over 20° ▶ ☐ RE _____ ☐ LE _____

C. Epilepsy

Indicate if the condition is under control with medication:

☐ No ▶ No medication succeeds in fully controlling seizures. Specify: _____

_____

☐ Yes

☐ Partially under control ▶ Specify since when: _____

Give specifics on the nature of seizures (types and signs) and any side effects of medication (if applicable):

_____

_____

Do particular situations provoke seizures? Yes ▶ Specify: _____

_____

If the person has severe seizures (with unconsciousness or convulsions), state how many times weekly on average these seizures occur:

_____

_____

If applicable, explain how the person's safety is compromised during travel: _____

_____

D. Severe and persistent mental health problems (complete Section F also, if applicable)

Are the person's disabilities controlled with medication?

☐ No ▶ Specify: _____

_____

☐ Yes

E. Cognitive disorders (complete Section F also, if applicable)

Specify if the person has cognitive problems (e.g., understanding, judgment, memory).

_____

_____

_____

F. Behaviour problems

In a transportation situation, could the person exhibit a behaviour problem (impulsiveness, aggressiveness, self-mutilation, runaway risk, etc.) that could be detrimental to his or her own safety or to that of other passengers, of which the carrier should be informed if the person is declared eligible for paratransit?

☐ No

☐ Yes ▶ Indicate the nature of the problem and how it manifests itself: _____

_____

_____

▶ Indicate the kind of situation that could lead to a transit-related behaviour problem: _____

_____

_____

G. Communication problems

Can the person communicate?

☐ Verbally ☐ Using signs ☐ With major speech problems ☐ Using gestures

☐ No communication ▶ Specify: _____

☐ Other ▶ Specify: _____

6 A. Do the person's limitations require the use of one of the following mobility aids to facilitate travel on paratransit?

☐ None ▶ Go to Question 7.

☐ Walker ▶ ☐ folding ☐ non-folding

☐ Rolling walker

☐ Cane ▶ Specify the type: _____

☐ Crutches

☐ Guide dog or assistance dog (certified by a recognized school)

☐ Three-wheeled scooter or four-wheeled scooter

☐ Wheelchair ▶ ☐ motorized ☐ manual (rigid) ☐ manual (folding)

☐ Other ▶ Specify: _____

B. Must the person use this aid?

☐ All the time ☐ Occasionally

Specify: _____

C. Can the person using a manual wheelchair perform a self-transfer to the seat of a vehicle?

☐ No, even with someone's assistance ☐ Yes, without help ☐ Yes, with someone's assistance

D. Does the person require bottled oxygen during paratransit travel?

☐ No ☐ Yes

7 If the applicant is declared eligible for paratransit, will the help of someone on board the vehicle be needed in light of the person's disabilities?

☐ No

☐ No, not if certain measures are taken to alleviate behaviour problems during travel.

▶ Explain: _____

_____

☐ Yes, temporarily during a period of familiarization of: _____

☐ Yes, all the time. ▶ Reason: _____

_____

8 **Has the person been registered for a course in orientation and mobility, a learning or familiarization process (treatment or behaviour therapy), or to rehabilitation for the purpose of using regular public transit?**

☐ No, because:

☐ The person does not have the potential. ► Explain: _____

☐ The person has the potential, but there is no regular public transit in the municipality.

☐ Other ► Specify: _____

☐ Yes, supervised by: _____ Telephone: _____

Name of facility: _____

Start date: _____ Probable duration: _____ End date: _____

If this initiative proved fruitless, explain the reasons:

_____

_____

9 **A. Could the person use regular public transit for some travel without accompaniment?**

☐ No ► Reason: _____

☐ Yes, for all trips.

☐ Yes, except in certain situations. ► Specify: _____

☐ Yes, for certain particular trips. ► Specify the origin and destination of those trips:

Origin	Destination

B. Could the person use regular public transit when accompanied?

☐ No ► Explain: _____

☐ Yes

10 **The information contained in this document concerning the diagnosis and assessment of disabilities comes from:**

☐ An assessment of the applicant. ► Specify the type of assessment, if applicable: _____

☐ The applicant's record: ☐ Diagnosis ► Specify the date: _____

☐ Assessment of disabilities ► Specify the date: _____

☐ Other ► Specify: _____

11 **How long have you been treating or providing services to that person?**

_____

This form was filled out by:

Family name, first name: _____

Position: _____

Stamp or seal of the professional or facility

Stamp or seal

Telephone: _____ Prof. licence No. (if any): _____

I certify that the information provided on (indicate first and family name) Mr. _____ or Ms. _____ is accurate. I understand that a false statement could lead to the rejection of the applicant eligibility application or the withdrawal of paratransit eligibility.

_____ Signature required

_____ Date (YYYY-MM-DD)

You may append additional information you deem necessary in support of this attestation.

THE CONTENT OF THIS FORM IS PRESCRIBED BY THE MINISTÈRE DES TRANSPORTS DU QUÉBEC.

Ministère des Transports

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This section must be completed by the applicant, by any other person designated by the applicant, or by the authorized person (legal representative) if the applicant is unable to do so. The information provided remains confidential and is for the exclusive use of the admission committee.

PLEASE PRINT CLEARLY

1. If the person were admitted to adapted transportation, would their limitations require them to have a responsible person at the destination?

☐ **YES** — The person is not autonomous and cannot remain alone without supervision. The driver must ensure that a responsible person takes charge of the individual before leaving the premises.

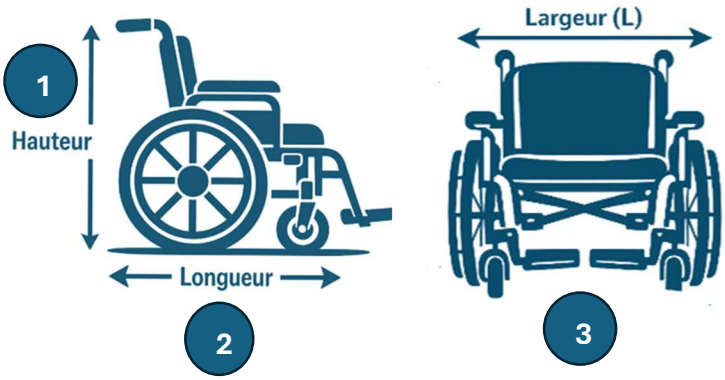
☐ **NO** — The person is autonomous; the driver may leave them alone at the destination.

2. Additional Emergency Contact

Would you like to add the contact information of an additional person we may reach in case of emergency?

Last Name		First Name	
Phone Number	Home	Work	Extension
Cell Phone		Email Address	
Relationship to the Applicant		Name of Institution (if applicable)	

3. For wheelchairs (motorized or manual), three-wheel scooters and four-wheel scooters, please indicate the following measurements:



1) **Maximum Height:** _____
(From the ground to the highest point)

2)Overall Length: _____

3)Overall Width: _____
(Maximum width of the wheelchair)

The adapted transportation service of **TAP** would like to remind you that it is your responsibility to keep your medical information and personal information up to date so that we can carry out our work in your best interest.