RIDE CK

Applicant Information (Please Print Clearly)

Applicant Name (Last) (First) **Date of Birth** (YY/MM/DD)

Street Address

City **Province** **Postal Code**

Phone (Home) **Phone** (Mobile) **Email Address**

Senior's Residence or Long-Term Care Facility (if applicable)

Emergency Contact Information (Optional – Please Print Clearly)

Name (Primary Contact) **Relationship to Applicant** **Phone**

Disclosure of Information

By signing below, you give permission to the Municipality of Chatham-Kent to contact the health care professional who completes **Part B** of your application form regarding your provided information in **Part A**.

Personal information contained on this form is collected by The Municipality of Chatham-Kent under the authority of the Municipal Act, 2001 and will be used by Transportation staff for the purpose of reviewing and processing your application. Questions regarding the collection and use of this information may be directed to the Municipal Clerk, 315 King Street West, Chatham, ON N7M 5K8, or by telephone at 519-360-1008, or email to ckclerk@chatham-kent.ca.

Signature of Applicant or Designate: ______________________________

Designate Name (if applicable): __________________________ **Date** (YY/MM/DD): _____________________

*****Please complete Part A questions on the next page and then have your health care professional complete Part B of this application.*****

RIDE CK

Applicant Self Declaration (Please Print Clearly)

1. I have read the Service Information provided in this Application Package or available at **www.rideck.ca** and believe my disability cannot be accommodated on conventional transit but can be accommodated on specialized public transit. ☐ Yes ☐ No

2. Please describe how the symptoms of your disability functionally prevents you from using conventional public transit equipped with accessibility features.

3. I am able to independently recognize my destination and seek assistance if I am at the wrong location. ☐ Yes ☐ No

4. I am able to independently access my home and other facilities in which I will be requesting transportation (i.e. unlock doors, navigate facility ramps/stairs/reception areas if applicable). ☐ Yes ☐ o

5. I am able to independently present fare for payment. ☐ Yes ☐ No

6. I am able to independently respond to my personal care or medical needs (i.e. administer medication) if it is likely to be required during transport. ☐ Yes ☐ No

If "No" to #3-6, your application approval will require you to bring a Mandatory Support Person with you on every trip.

7. I am able to remain on a vehicle for up to one hour and travel alongside other passengers. ☐ Yes ☐ No

8. I am able to be safely transported at regular vehicle speeds. ☐ Yes ☐ No

9. My combined weight with my personal mobility device (i.e. wheelchair) is less than 272 kg (600 lbs) and does not exceed 76 cm (30 inches) in width and 106 cm (42 inches) in length. ☐ Yes ☐ No

If "No" to #7-9 please contact a non-emergency medical transportation carrier for your transportation needs.

10. I may bring the following mobility device(s) with me on transit:

Manual Wheelchair ☐ Power Wheelchair ☐ Mobility Scooter ☐ Walker ☐ Other ______________________

***Please note users of mobility scooters will be required to transfer to a bus seat after boarding.**

To be completed by the Health Care Professional

Question		
1. I agree with the Applicant's information in Part A and understand **this is not an attendant-care transportation service**.	☐ Yes	☐ No
2. Does the Applicant have any behavioural concerns that pose a safety risk to themselves or others on board the vehicle, or does the Applicant have a risk of exiting the vehicle and wandering? **If "yes" the Applicant will be required to bring a Mandatory Support Person with them on every trip capable of managing these concerns.**	☐ Yes	☐ No
3. It is my professional opinion the Applicant's disability cannot be accommodated on conventional public transit but can be accommodated on specialized public transit.	☐ Yes	☐ No
4. How long is their disability expected to prevent then from effectively using conventional transit?	☐ **Long-term**: No Expectation of improvement ☐ **Temporary**: Expected duration until ______________________ (YY/MM/DD) ☐ **Conditional**: Applicant's condition only prevents ability to use conventional transit during winter conditions (i.e. snow/ice)	

I hereby certify that the information provided in Part B is true for:

Applicant Name: ______________________________

Health Care Professional Information:

Full Name	**Profession**
Contact Number	**Licence/Certification Number**
Signature	**Date** (YY/MM/DD)

Applicant is responsible for dropping off Part A and Part B at any Municipal Centre or by mail, email, or fax. Please allow 14 calendar days for application review.

Municipality of Chatham-Kent
Attn: Engineering & Transportation
PO Box 640, 315 King Street West
Chatham, ON N7M 5K8

Email:
ck311@chatham-kent.ca
Subject Line: Specialized Transit Application

Fax:
519-436-3240