

**STO**Société de transport
de l'Outaouais

Eligibility Criteria

- A. **Be a handicapped person, meaning "a person with a deficiency causing a significant and persistent disability, who is liable to encounter barriers in performing everyday activities."**
- B. **In terms of mobility, have difficulties that justify the use of a paratransit service.**

Nonetheless, temporary limitations (such as a broken leg) do not qualify as a reason to be eligible for paratransit service.

You can check the *Paratransit Eligibility Policy* on the Transports Québec Web site at <http://www.mtq.gouv.qc.ca/> under the Persons with Disabilities section.

2. Instructions

A. Part 1: To be completed by the applicant.

B. Part 2: To be completed by a professional in the health care system or school system who has access to the applicant's diagnosis.

Motor or organic impairment:

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

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

Intellectual impairment: Special education teacher, psychoeducator, psychologist or social worker (if not registered with a rehabilitation centre for intellectual impairments (CRDI))

Visual impairment: Orientation and mobility specialist.

Psychological impairment: Occupational therapist, nurse or social worker, all working in the field of psychological impairments.

The STO's paratransit service would like to remind you that it is your responsibility to keep information pertaining to your medical condition, and your personal information up to date to allow us to carry out our work in your best interests.



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 an 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 an 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 | Area code | | Number | | | Work | Area code | | Number | Extension | |
| Home | | | | | | | | | | | |
| Cell | Area code | | Number | | | Fax | Area code | | Number | | |
| | | | | | | | | | | | |
| Email address | | | | | | | | | | | |
| Date of birth | | Year | | Month | | Day | | Gender | | Weight | Height |
| | | | | | | | | <input type="checkbox"/> Female <input type="checkbox"/> Male | | | |
| Language spoken | <input type="checkbox"/> French | <input type="checkbox"/> English | Other means of communication | | | | | | | | |
| | <input type="checkbox"/> Other, specify: | Specify: | | | | | | | | | |

SECTION 2

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

1 Why are you making an application for paratransit eligibility?

2 Is there regular 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 trip on paratransit?

- No Yes

B. Specify the aid(s) required.

- Walker ► folding non-folding Three-wheeled scooter or four-wheeled scooter
 Rolling walker Wheelchair ► motorized
 Cane ► Specify the type: _____ manual (rigid)
_____ manual (folding)
- Crutches Other ► Specify: _____

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

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

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

- No Yes

5 Do you have dependent children under age 14?

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

| Family name | First name | Date of birth | | |
|-------------|------------|---------------|-------|-----|
| | | Year | Month | Day |
| _____ | _____ | _ _ | _ | _ |
| _____ | _____ | _ _ | _ | _ |
| _____ | _____ | _ _ | _ | _ |

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 | Area code | Number | Work | Area code | Number | Extension |
| | Home | | | | | |
| | 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 | Area code | Number | Work | Area code | Number | Extension |
| | Home | | | | | |
| | 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 of a condition resulting in 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 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 age six.
- 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:

Explain how the person's safety is compromised during travel, if so: _____

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 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 particular 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 appropriate: _____
- 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: _____

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

Stamp or seal of
the professional
or facility

Stamp or seal

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 person's 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.

This part must be completed by the applicant, by a person designated by the applicant or by the authorized person (applicant's legal representative) if the applicant is unable to act.

The information provided shall remain confidential and for the exclusive use of the eligibility committee.

PLEASE PRINT

1. If the person is accepted for paratransit service, will his/her limitations require the assistance of an attendant at the destination?

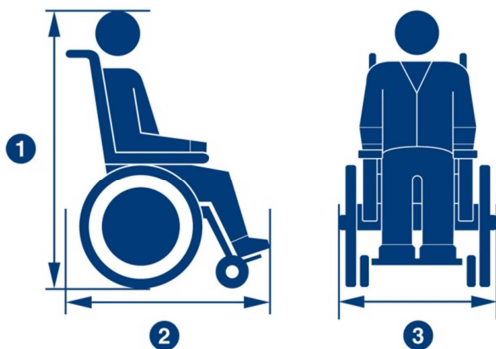
- Yes The person is not autonomous and cannot be left unattended. The driver must ensure that the person is in the care of an attendant before driving away.
- No The person is autonomous, the driver can leave him/her unattended at the destination.

2. Additional emergency contact.

Would you like to add the information for another contact person in case of an emergency?

| | | | |
|-------------------------------|----------------|-------------------------------------|-----------|
| Last name | | First name | |
| Telephone no. | Home | Work | Extension |
| Cell | E-mail address | | |
| Relationship to the applicant | | Name of institution (if applicable) | |

3. For wheelchairs (motorized and manual) or scooters, please provide the following measurements:



- | | |
|---|-------|
| 1) Maximum height: (from the ground to the highest part) | _____ |
| 2) Overall length: | _____ |
| 3) Overall width: (maximum width of the wheelchair) | _____ |

The STO's paratransit service would like to remind you that it is your responsibility to keep information pertaining to your medical condition, and your personal information up to date to allow us to carry out our work in your best interests.