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 service.

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 to 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 250-390-3000 in Nanaimo –or– 250-248-4557 in Parksville / Qualicum Beach and ask for Client Registration.

NOTE: If your application for handyDART is denied, you may appeal this decision. Please call 250-390-3000 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 _________/_____/__________ Female ( ) Male ( )

month day year

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 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?
   Answer: __________________________________________________________

2. Does your disability include any of the following cognitive and/or physical mobility issues?
   (Please check all that apply and indicate any other factor you feel should be noted.)
   - Unable to walk three city blocks  ( )
   - Unable to walk up and down steps  ( )
   - Unable to stand for 15 minutes  ( )
   - Unable to travel on buses due to fatigue  ( )
   - Unable to sit or rise unassisted  ( )
   - Shortness of breath due to exertion  ( )
   - Unable to see signs or notices  ( )
   - Unable to plan a trip and travel alone outside the home  ( )
   - Unable to travel unassisted due to confusion, or cognitive or organizational limitations  ( )
   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  ( )
   - Cane  ( )
   - White cane  ( )
   - Manual wheelchair  ( )
   - Crutches  ( )
   - Prosthetic device/orthotic device  ( )
   - Three-wheel scooter  ( )
   - Walker  ( )
   - Portable oxygen tank  ( )
   - Four-wheel scooter  ( )
   - Service animal  ( )
   - 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 that could enable you to use regular transit buses some of the time?  Yes ( ) No ( )
   Are you interested in a handyPASS, which is required to purchase TaxiSaver coupons and allows for your attendant to travel free on regular transit buses?  Yes ( ) No ( )
   If yes, a representative will contact 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 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_________________________________________Phone#________________________

( ) Physician ( ) Occupational therapist ( ) Physiotherapist
( ) Registered nurse ( ) Social worker ( ) Long term Care case manager

A. Applicant Signature or Advocate or spokesperson completing form for applicant (please check one)

________________________________________
Signature of Applicant

________________________________________
Date

________________________________________
Please send completed application to:
Nanaimo Regional handyDART
6300 Hammond Bay Road
Nanaimo BC
V9T 6N2

[ ] 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#