

Cochrane Access Transit Visitor Application Form



INFORMATION SHEET

Once the form is completed, please return Parts A & B to
Clerks Dept, Town of Cochrane, 171 Fourth Avenue, Cochrane, ON, P0L 1C0

To apply for registration for the Town of Cochrane's Access Transit Program please complete this form in full. This service operates only within the boundaries of the Town of Cochrane. It is a transportation service offered to anyone who meets one or more of the eligibility guidelines on a permanent or temporary basis. The eligibility guidelines for the use of the Access Transit are as follows:

- Persons who are physically unable to climb or descend steps used on conventional public transit facilities.
- Persons unable to walk a distance of 175 meters (575 feet).
- Visually impaired persons are subject to a confirmation letter from C.N.I.B. attached to the application.

Completing the Form:

This form is intended for Cochrane who require temporary or long-term access to Access Transit services. Visitors to Cochrane or individuals who require emergency or compassionate access must complete the application form specific to their needs.

Part A - To be completed by or on behalf of the applicant and signed by the applicant or an appointed Power of Attorney.

Part B - To be completed by the applicant's Physician / medical professional and can be returned separately. **Visitors may forego completing Part B of this form if they can confirm eligibility for specialized transportation services in their home jurisdiction.**

All information in this application will remain confidential and will only be used to process applicant eligibility.

Persons travelling with a Access Transit subscriber:

AIDE: If you require a support aide to travel with you, it **MUST** be stated on the application form on page 1. Please be advised that a **support aide** is an individual required to assist the applicant for mobility or cognitive reasons; the Town does not provide people to travel with you. That is the applicant's responsibility. This person does not need to pay fares, but our provider, Flash Co Taxi, will need to be informed when reserving your ride. Anyone acting as an aide must be 18 years of age or older. An aide cannot be someone who is also registered as an Access Transit subscriber.

SOCIAL COMPANION: Is any person travelling with you as a friend or companion and NOT fulfilling the role of an Aide to offer assistance. **Social companions are required to pay the appropriate fare.**

DEPENDENTS OR CHILDREN: Any persons travelling with dependents/children are permitted to use the Access Transit service if they are the parent or guardian. The Provider is not responsible for providing child restraint systems; that is the subscriber's responsibility.

Please complete ALL sections of the application to avoid delay and submit to:
Town of Cochrane Clerk's Department, 171 Fourth Avenue, Cochrane, ON P0L 1C0

Email: clerk@cochraneontario.com
Tel: [705-272-4361](tel:705-272-4361) Fax: 705-272-6068

We will notify you via mail of your eligibility. We may call you or your physician to obtain more information about your condition if we require additional information. If you have not been notified within ten (10) days of submitting your application, please call us at 705-272-4361

Alternative formats of this application will be made available upon request.

**Please contact the Clerk's Department by calling (705) 272-4361 or email: clerk@cochraneontario.com
Or visit 171 Fourth Avenue, Cochrane, ON**

Personal information is collected under the authority of the Municipal Act 2001, R.S.O. 2001, c. 25 (as amended) and in accordance with the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990. C. M.56 and will be used solely to determine eligibility for para-transit services as provided by the Town of Cochrane.

Cochrane Access Transit Visitor Application Form



Part A: Applicant Information and Travel Requirements (Applicant to complete)			
Name of applicant (please print): _____			
Address of Applicant: _____			
Date of Birth: _____	Email: _____	Phone Number: _____	
Duration of Visit			
Anticipated number of days that the Applicant will be visiting the Town of Cochrane: _____ days			
Emergency Contact Information			
Emergency Contact Name: _____		Phone Number: _____	
Address: _____			
Relationship to Applicant: _____		Email: _____	
Send a Copy of Confirmation to the Emergency Contact. (check one)		Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Accessibility Information			
Family Physician Name: _____			
Family Physician Phone Number: _____			
Do you use a wheelchair? (check one)		Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Do you use a walker? (check one)		Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
If yes, is the walker foldable (check one)		Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Do you need an <u>Aide</u> to travel with you? (check one) (details on front page)		Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
If yes, when is the assistant required? (check one)	On all rides <input type="checkbox"/>		For specific assistance <input type="checkbox"/>
State specific reasons/diagnosis for requiring Access Transit assistance:			
Signature of Applicant or POA			
<p>I certify the information provided on this application is accurate. I also authorize the health care professional named on Part B of this form to provide information to the Town of Cochrane Clerk's Department I. I understand that misinformation or misrepresentation of the facts will be cause for disqualification or rejection of my eligibility. I also understand that additional information relating to my disability or health condition may be required to determine eligibility. I hereby consent to the Town of Cochrane to contact my physician when additional information or clarification is required.</p>			
Signature of Applicant / POA: _____		Date: _____	
If you have completed this form as a POA on behalf of the applicant, please provide the following information:			
Name: (please print): _____		Phone: _____	
Relationship to applicant: _____			
<p>When you have completed Part A of this form, provide the Cover Page, Part A <u>and</u> Part B to your healthcare professional.</p>			

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Part B: Medical Information (To Be Completed By Your Health Care Professional)				
You do not have to complete Part B if you are attaching confirmation of eligibility for specialized transportation services in your home jurisdiction to this application form				
Provide the following information:			Physician's Office Stamp (required)	
Applicant Name:				
Physician Name:				
Street #:	Unit #:			
Street Name:				
Town:				
Postal Code:				
Office Phone #:				
Profession (check one):	Family Physician: <input type="checkbox"/>	Nurse Practitioner: <input type="checkbox"/>	Other Medical Professionals: <input type="checkbox"/>	
If other, please specify the area of specialty:				
Access Transit Eligibility Guidelines				
<p>Cochrane Access Transit is a transportation service offered to eligible persons in the community of Cochrane and only within the limits of Town. The eligibility guidelines are as follows:</p> <ul style="list-style-type: none"> • Persons physically unable to climb or descend steps • Persons unable to walk a distance of 175 meters (575 feet) • Visual impairment (confirmation letter from CNIB required) • Persons who are temporarily disabled due to illness/injury 				
Application Review				
I have read part A in its entirety:		Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	
I agree with the Information in Part A:		Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	
If no, please explain:				
In your opinion, does the applicant require an Aide to accompany them?			Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
State specific reasons/diagnosis for requiring Access Transit assistance: (please be specific):				
Severity of Condition:	Mild: <input type="checkbox"/>	Moderate: <input type="checkbox"/>	Severe: <input type="checkbox"/>	
Expected Duration of Disability:	<input type="checkbox"/> Temporary	Expected Duration: _____ months _____ years		
	<input type="checkbox"/> Permanent (the nature of the disability will not change)			
Physician Signature				
I hereby certify that the above information contained in Part B of this form to be true:				
Physician Signature: _____ Date: _____				