APPLICATION FOR SUPPORT PERSON PASS, CONVENTIONAL TRANSIT

You may be eligible for a Support Person Pass if you are unable to travel independently and require assistance on conventional transit.

In order to be eligible to have a support person accompany you free of charge on any conventional transit service, you are required to:

- complete Part "A" of this application
- have your health care provider complete Part "B" of this application – a listing of approved professionals is found on the last page of this application package

Please note that all conventional transit is fully accessible for those with mobility, visual, cognitive or other disabilities.

If approved, a Support Person Pass will be issued to you which enables you to travel with one passenger of your choice at no additional charge. Please note that you will be required to present your Support Person Pass at the time of boarding in order to receive this benefit.

PLEASE NOTE:
The following excerpt taken from the Integrated Accessibility Standards (IASR) Act., Regulation 191-11

38.

(1) No conventional transportation service provider and no specialized transportation service provider shall charge a fare to a support person who is accompanying a person with a disability, where the person has a need for a support person.

(2) It is the responsibility of a person with a disability to demonstrate to a transportation service provider described in subsection (1) their need for a support person to accompany them on the conventional or specialized transportation service and to ensure that the appropriate designate for a support person is in place.

For questions please contact:
905-980-6000, ext. 3550 or 1-888-263-7215, ext. 3550

SUBMIT PART "A" AND "B" OF THIS APPLICATION TO:

In person or by mail:
Niagara Region
Transportation Services
1815 Sir Isaac Brock Way
P.O. Box 1042
Thorold, ON L2V 4T7

Email:
transit@niagararegion.ca

Fax:
905-685-0013

PART "A" PERSONAL INFORMATION | SECTION 1

PERSONAL INFORMATION (Please print)

Applicant name:	
Date of birth: *month / day / year*	
Address: *Complete with street number, name, city, postal code and name of residence, if applicable.*	
Primary phone number:	Alternate phone number:
Email address:	

I hereby certify to the best of my knowledge that the information given in this application is correct. By signing below, I hereby authorize the Niagara Region or their agents to use this application to determine my eligibility by reviewing the information contained herein. I further authorize the Health Care Professional who signed Part "B" of this application to release any information to the Niagara Region or their agents for purposes of determining eligibility. In addition, I certify that my consent is freely given to the Niagara Region or their agents to share the information contained within this application with other transit service providers for the purpose of providing this service.

By signing below, I am aware that my continued eligibility may be re-assessed by NIAGARA REGION or their agents.

Signature of applicant:	Date:
Signature of guardian or power of attorney *(proof may be required)*	Date:
Name of guardian or power of attorney: *(if required, please print)*	
Address of guardian or power of attorney: *Complete with street number, name, city, postal code and name of residence, if applicable.*	

PART "A" PERSONAL INFORMATION | SECTION 2

How does your disability prevent you from accessing conventional transit services independently, given that all transit vehicles in Niagara have accessibility features such as wheelchair ramps, destination signage, stop announcement systems, and low floor/ kneeling buses?
Please describe the type of assistance your support person will provide during your transit trip:

OFFICE USE ONLY	
Review Date: *month / day / year*	
Approved: Permanent	Temporary Until: *month / day / year*

PART "B" MEDICAL INFORMATION

TO BE COMPLETED BY A HEALTH CARE PROFFESSIONAL

To the Health Care Professional:

You are being asked by the applicant named in **PART "A"** of this application to provide information regarding their ability to make use of the following transit option:

PART "A" Support Person Card Identification:

If approved, this allows the transit user to have a support person ride free with them on any conventional transit system.

Please review PART "A" of this application to understand the intent of the applicant.

An applicant's eligibility for a Support Person Card is directly dependent on their inability to use conventional, accessible transit independently. It does not necessarily depend on medical problems such as cardiovascular disease, pulmonary disease or old age, but they may be taken into consideration as additional factors. In addition, a lack of local conventional transit does not consititute eligibility for specialized transit services.

Please note: that all conventional transit has accessibility features to support those with mobility, visual, cognitive or other disabilities. These features include, but are not limited to: wheelchair ramps and restraint systems, low floor/ kneeling buses, destination signage and stop announcement systems.

COMPLETE THE FOLLOWING: (Please print)

Applicant Name:	Date:	
In your professional opinion does the applicant have a disability that requires them to have a support person in order to use transit? (i.e., they are not able to self-direct their own care while on board the vehicle)	YES	NO
If this is a temporary condition, please advise of an approximate date that the applicant could begin to independently use transit.	Date:	

I HAVE READ PART "A" IN ITS ENTIRETY

Name of Health Care Professional:	Telephone:
Address of Health Care Professional: *Complete with street number, name, postal code and name of residence, if applicable.*	

HEALTH CARE PROFESSIONAL COMPLETING THIS FORM IS A MEMBER OF: *Check all that apply*

	College of Physiotherapists of Ontario		College of Nurses of Ontario
	College of Physicians and Surgeons of Ontario		College of Audiologists & Speech-Language Pathologists of Ontario
	College of Chiropractors of Ontario		College of Psychologists of Ontario
	College of Optometrists of Ontario		College of Occupational Therapists of Ontario
	College of Registered Psychotherapists & Registered Mental Health Therapists of Ontario		

Signature:	Date:
Please print name:	Date: