



If you have a disability that prevents you from using fixed-route service some, or all of the time, you may be eligible for door-to-door handyDART service.

Please complete all sections of this form. Our staff will contact you to discuss your application and travel options.

By checking this box you acknowledge that the personal information provided by you is collected under Section 26(c) of the *Freedom of Information and Protection of Privacy Act* and will be used for the purpose of determining eligibility for custom transit pursuant to Section 11 of the British Columbia Transit Regulation (B.C. Reg. 30/91). If you have any questions about the collection, use or disclosure of this information, please contact BC Transit's Privacy Office by telephone at 1-250-385-2551; via email to [Privacy@BCTransit.com](mailto:Privacy@BCTransit.com); or by regular mail to 520 Gorge Road East, Victoria, BC V8W 2P3.

## CONTACT INFORMATION

PLEASE PRINT

### 1. Permanent Address

FIRST NAME	LAST NAME
ADDRESS	SUITE #
CITY	POSTAL CODE
HOME PHONE	CELL PHONE
EMAIL	

### 2. If your current mailing or temporary address is different from your permanent address (example: care facility or hospital), complete the following:

FIRST NAME	LAST NAME
ADDRESS	SUITE #
CITY	POSTAL CODE

### 3. Pickup Location and Accessibility

Do your driveway and road provide clearance for a tall vehicle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the walkway and entry level clear of obstacles?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any concerns regarding a handyDART vehicle safely accessing your pickup location?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### 4. Secondary Contact

FIRST NAME	LAST NAME	RELATIONSHIP
DAYTIME PHONE	EVENING PHONE	

## PERSONAL INFORMATION

5. Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR
6. Gender  MALE  FEMALE  OTHER \_\_\_\_\_  PREFER NOT TO DISCLOSE

## TRANSPORTATION DISABILITY INFORMATION

7. Describe why BC Transit's accessible, fixed-route service is not an option for you, some or all of the time, based on your cognitive and/or physical functional mobility limitations.

8. Describe your travel abilities and limitations.

I am able to:	Always	Sometimes	Never
Walk/roll 3 city blocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk up and down steps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand for 15 minutes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit down or rise without assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ask for or receive travel directions verbally, or in writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
See signs and read directions clearly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Is your mobility limitation  Permanent

Or  Temporary, specify until when  
(date can be extended as required)

Surgery date  
(when applicable)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
MONTH DAY YEAR

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
MONTH DAY YEAR

10. Can you be left alone at your residence?  Yes  No, explain below:

NOTE: Your secondary contact will be called if someone is not available to receive you at home.

11. Do you need an attendant to travel with you due to a cognitive condition, confusion, or disorientation?

No  Yes, explain, \_\_\_\_\_

12. Do you use any of the following aids? Check all that apply and let the handyDART office know the type and size of equipment when booking:

Power wheelchair with lapbelt and foot rests

Manual wheelchair with lapbelt and foot rests

\_\_\_\_\_ approximate combined weight of wheelchair and passenger

3-wheel scooter

4-wheel scooter

Walker

Cane

Oxygen tank

Certified service animal

## TRAVEL OPTION INFORMATION

We encourage our customers to use fixed-route service for some trips, and to use handyDART only as needed.

13. Do you use fixed-route service for some of your trips?  Yes  No

If no, are you interested in learning how to travel independently on the bus for some of your trips?

- Yes, I am interested in receiving free training that will teach me how to use the bus at my own pace with a qualified trainer.
- No, I do not wish to receive free training.

14. BC Transit can obtain my mobility information from one of the following (check one only):

- |  |   |
|--|---|
| <input type="checkbox"/> Licensed Physician                  | <input type="checkbox"/> Licensed Optometrist                   |
| <input type="checkbox"/> Certified Rehabilitation Specialist | <input type="checkbox"/> Registered Occupational Therapist      |
| <input type="checkbox"/> Registered Recreation Therapist     | <input type="checkbox"/> Registered Vocational Therapist        |
| <input type="checkbox"/> Health Authority Case Manager       | <input type="checkbox"/> Registered Nurse or Nurse Practitioner |

Please provide the information for the contact you selected above.

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NAME

PHONE

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MAILING ADDRESS

## AUTHORIZATION

15. The information provided in this form is solely for the use of BC Transit and Agents to determine your eligibility for custom transit services. By completing this application, you or your legal representative declare that you understand and authorize the following:

- You have a disability, medical condition, or age related frailty that prevents you from using the regular bus some or all of the time.
- You consent to the disclosure of personal information by your medical practitioner (Doctor, Therapist, Case Manager) to BC Transit or its agents.
- You acknowledge that you may be requested to undergo a functional assessment.
- BC Transit can re-assess your eligibility if it appears your transportation needs have changed.
- You allow a site visit, at your primary pick-up location, and a mobility assessment by a BC Transit representative.
- I certify that the information provided in this application is true to the best of my knowledge.

\_\_\_\_\_  
SIGNATURE OF HANDYDART APPLICANT

\_\_\_\_\_  
DATE

### FOR LEGAL REPRESENTATIVE\* USE ONLY

\_\_\_\_\_  
FIRST NAME OF LEGAL REPRESENTATIVE

\_\_\_\_\_  
LAST NAME OF LEGAL REPRESENTATIVE

\_\_\_\_\_  
RELATIONSHIP TO APPLICANT

\_\_\_\_\_  
PHONE OF REPRESENTATIVE

\_\_\_\_\_  
EMAIL OF REPRESENTATIVE

\_\_\_\_\_  
SIGNATURE OF LEGAL REPRESENTATIVE

\_\_\_\_\_  
DATE

*\*Legal Representative: The Representation Agreement Act allows you to appoint someone as your legal representative to handle your financial, legal, personal care and health care decisions, if you're unable to make them on your own. You cannot appoint any person who is paid to provide you with personal or health care or who is an employee of a facility through which you receive personal or health care, unless that person is your child, parent or spouse.*

### SEND COMPLETED APPLICATION TO:

Client Registrar  
5130 Park Avenue  
Terrace, BC V8G 5S7  
OR Fax: 1-877-376-1018

**For more information, call 250-635-2666.**