On-Demand Accessible Transit
Registration Form

Section 1: APPLICANT INFORMATION
(to be completed by the Applicant) Please print clearly

GENERAL INFORMATION

Name: _____
First Last Middle Initial

Address: _____
Civic Address Apt/Unit #

Mailing Address (if different from above) _____

Telephone: _____ _____ _____
Home Cell Work

Date of Birth: _____/_____/_____ Email Address: _____
DD MM YYYY

Name of the building or facility, if applicable (e.g. Western Long-Term Care):

_____

Pick up Door details (e.g. side entrance, red door, etc)

_____

Gender (optional)

☐ Male ☐ Female ☐ Non-Binary ☐ Other

If applicable, please identify your pronouns: _____

Alternative Contact Person (If applicable):
Name: _____ Email:_____

Telephone: _____ _____ _____
Home Cell Work

Please choose the option that applies to you:

☐ I am a new applicant
☐ I am applying to renew my eligibility
☐ I am a visitor to the City. Duration of stay: _____

Emergency Contacts

Name: _____

Relationship to the applicant: _____

Telephone: _____ _____ _____
Home Cell Work

Name: _____

Relationship to the applicant: _____

Telephone: _____ _____ _____
Home Cell Work

Disability Information

Which of the following disabilities or health conditions, if any, prevent you from using the regular transit system? Check all that apply:

- ☐ Physical Disability
- ☐ Vision Loss
- ☐ Blind
- ☐ Mental Health Disability
- ☐ Cognitive Disability
- ☐ Deaf
- ☐ Hearing Loss
- ☐ Seizure Disorder
- ☐ Intellectual Disability
- ☐ Autism Spectrum Disorder
- ☐ Speech Disability
- ☐ Other (Please specify):
- ☐ None

Please tell us how your disability prevents you from using the regular transit service.

_____

_____

Can you travel a city block (175 m or 575 ft) on your own or using an assistive device?

- ☐ Yes
- ☐ No
- ☐ Sometimes

Are you able to travel to the stop nearest to your home?

- ☐ Yes
- ☐ No
- ☐ Sometimes

Can you wait at the bus stop?

☐ Yes
☐ No
☐ Sometimes

Can you recognize and understand destination and route signage at the bus stop and on buses?

☐ Yes
☐ No
☐ Sometimes

Can you recognize and understand where and when to board and exit the bus?

☐ Yes
☐ No
☐ Sometimes

Can you manage fare payment when boarding the bus (using cash or bus pass) and/or request a transfer?

☐ Yes
☐ No
☐ Sometimes

Can you transfer from one bus route to another?

☐ Yes
☐ No
☐ Sometimes

Is your disability expected to change over time? How so?

_____

_____

_____

Is your disability temporary or permanent?

☐ Temporary ☐ Permanent

If your disability is temporary, how long do you expect to need CBT Link?

☐ 3 months
☐ 6 months
☐ 1 year
☐ Other (please specify):

Mobility Aids and Assistance

Please select which mobility aid(s) you use when travelling outside your home:

☐ Wheelchair*:
☐ Manual
☐ Powered
☐ Oversized
☐ Scooter

☐ Walker
☐ Support cane
☐ Long white cane
☐ Crutches
☐ Communication board
☐ Service animal
☐ Oxygen tank
☐ Hearing aid(s)
☐ Other (please specify):

_____

Can you climb three (11 – 15-inch) steps with a handrail, without assistance from another person?

☐ Yes
☐ No
☐ Sometimes

Will you be traveling with an attendant?

☐ Yes
☐ No
☐ Sometimes

What supports do you require when using CBT Link? (I.e. help with steps, verbal directions, visual guide, etc.) Please explain:

_____

_____

_____

Additional Information

Which of the following modes of transportation do you currently use?

☐ Own vehicle
☐ Travel with family members or friends
☐ Regular Transit
☐ Taxi
☐ Other (please explain:

Is there any other information which would help us provide you with the most accessible service we can? Please explain:

_____

_____

_____

In which format would you like information sent to you:

☐ Regular print
☐ Large print
☐ Braille
☐ Electronic (E-mail address: _____)

Would you like to receive e-mail/text notices from CBT Link? These notices would be for service-related information (not for individual trips) such as policy changes, service interruptions, etc.

☐ Yes

☐ No

E-mail address: _____ Text #: _____

Advocate Information

Please complete this section if this form is being completed by someone on behalf of the applicant.

Advocate's Name: _____

Relationship to applicant: _____

Agency (if applicable):_____

Phone:_____ Email: _____

Consent/Declaration

I understand that the information provided on this form and as part of this process is required for the purpose of determining eligibility to use CBT Link Accessible Transit. Collection of this information is authorized under the Access to Information and Protection of Privacy Act, 2015 and the Personal Health Information Act (PHIA) and will only be utilized by authorized staff and/or contractors to fulfill the purpose for which it was originally collected. Questions about the collection and use of the information may be directed to the City Clerk @ 709-637-1534.

I acknowledge that information related to my usage of CBT Link (such as date/time of trip, status of trip, origin/destination address, passenger type) may be shared with municipalities, governments or agencies responsible for the financial subsidization of Accessible Transit. No personal information will be shared with other public bodies or individuals except as authorized by ATIPPA, 2015.

I give permission for myself, my advocate and/or my health care professional to be contacted if additional information or clarification is required to determine my eligibility to use CBT Link.

I authorize the release of my medical information as contained in Section 2 of this application to Accessible Transit Services and the Assessment Service Provider for the purpose of determining my eligibility to use CBT Link Accessible Transit.

I certify that to the best of my knowledge, the information on this application is true and correct. I understand that providing false or misleading information could result in my eligibility status being terminated. I understand that applying for CBT Link service does not guarantee acceptance as a customer of the CBT Link service.

Signature: _____ Date: _____

Section 2: HEALTH CARE PROFESSIONAL INFORMATION
(to be completed by the Health Care Professional) Please print clearly

This section is to be completed by a registered health care professional (such as a physician, Nurse Practitioner, social worker, physiotherapist, mental health professional, or occupational therapist) who is familiar with the applicant and can provide details on how their disability prevents the use of conventional transit.

This information is requested in order to determine the applicant's eligibility to use CBT Link Accessible Transit.

Consent to Release Information

I, _____ (applicant's name), provide my consent to the release of the following medical information to the City of Corner Brook for the purpose of determining my eligibility to use CBT Link Accessible Transit. All medical information obtained within the application process is managed in accordance with the Personal Health Information Act (PHIA) NL.

Applicant's Signature: _____ Dated: _____

Applicant Information

Name: _____ Date of Birth: _____

Health Care Professional Information

Name:_____

Occupation/Specialty: _____

Address: _____

Phone: _____ E-mail: _____

The applicant is applying to use CBT Link Accessible Transit, a shared ride door-to-door public transit service for persons with disabilities who are unable to use conventional transit for all or part of their trip. The information you provide will assist the City of Corner Brook in determining the applicant's eligibility for CBT Link.

Please provide details to indicate how the applicant's disability would impact their ability to utilize regular transit.

Physical Disability

☐ Permanent ☐ Temporary for_____months

Vision Disability

☐ Permanent ☐ Temporary for_____months

Cognitive Disability

☐ Permanent ☐ Temporary for_____months

Sensory Disability

☐ Permanent ☐ Temporary for _____months

Mental Health Disability

☐ Permanent ☐ Temporary for _____months

Other Disability (if applicable)

☐ Permanent ☐ Temporary for _____months

Do the above limitations vary under certain conditions, such as season or time of day?
Please explain:

_____

_____

_____

Does the applicant require an attendant/support person to travel outside the home?

☐ Yes
☐ No

Can the applicant be left alone at their destination (home or other)? If no, please explain:

_____

_____

_____

Eligibility for CBT Link may be granted if a person experiences disability-related barriers that prevent them from using regular transit (at all or under certain conditions). Using regular transit would require the applicant to be able to complete a variety of activities.

Please indicate the degree to which the applicant can complete the following activities:

Travel to nearest bus stop

☐ Attainable
☐ Possible with support
☐ Possible with training
☐ Impossible

Wait at bus stop until bus arrives (bus stops may or may not have seating)

☐ Attainable
☐ Possible with support
☐ Possible with training
☐ Impossible

Board the bus (by stepping from the curb into the bus or entering via ramp)

☐ Attainable
☐ Possible with support
☐ Possible with training
☐ Impossible

Maneuver wheelchair or scooter into the accessible space, if applicable

☐ Attainable
☐ Possible with support
☐ Possible with training
☐ Impossible

Recognize when to get off the bus and use the bell to signal a stop

☐ Attainable
☐ Possible with support
☐ Possible with training
☐ Impossible

Disembark the bus (by stepping from the bus to the curb or exiting via ramp)

☐ Attainable
☐ Possible with support
☐ Possible with training
☐ Impossible

Understand bus schedules and trip planning, including bus transfers if required

☐ Attainable
☐ Possible with support
☐ Possible with training
☐ Impossible

Has the applicant completed any functional assessments (e.g. TUG, MOCA) of their disability in the last 24 months that measure their ability to travel independently in the community?

☐ Yes
☐ No

If yes, please provide the following information:

Date of assessment _____

Name of test/evaluation_____

Purpose of test/evaluation _____

Results and impact (mild, moderate, severe) Mobility Aids

Does the applicant require the use of a mobility device when travelling outside their home?

☐ Yes
☐ No

If yes, please specify: _____

☐ Wheelchair (powered, manual, oversized)
☐ Scooter
☐ Walker
☐ Support cane
☐ Long white cane
☐ Crutches
☐ Communication board
☐ Service animal
☐ Oxygen tank
☐ Hearing aid(s)
☐ Other (please specify): _____

Additional Information:

Please provide any other information you deem relevant to this application.

_____

_____

_____

Application completed by:

Health Care Professional's Name: _____

Signature:_____ Date: _____

Thank you!

Please return completed forms to the City of Corner Brook by mail or e-mail.

City of Corner Brook
Community Services, Engineering, Development and Planning
P.O. Box 1080
Corner Brook, NL A2H 6E1
Telephone: 709-637-1666
Email: transit@cornerbrook.com