



## APPLICATION FORM Yellowknife Accessible Transit System



There are two sections to be completed in this application. **Section A** must be completed and signed by the applicant or someone the applicant selects to help with the application. **Section B** must be completed and signed by a healthcare professional. If you need assistance to complete the application, please call the NWT Disabilities Council at 873-8230 or Toll Free at 1-800-491-8885.

### Re-evaluation Period

Applicants with permanent disability status will be required to reapply for YATS service every 5 years. In the event that YATS staff notice changes in the applicant's abilities that void the current information on file, the applicant will be asked to resubmit their application with up-to-date information.

Applicants with seasonal status will be required to reapply for YATS each year.

It is the applicant's responsibility to inform YATS of any changes to their status (i.e. new address or phone number, change in condition) by calling the NWT Disabilities Council at 873-8230. If the changes are significant, the applicant may be required to resubmit their application.

### OFFICE USE ONLY – DO NOT FILL IN

Date Received		Date Approved	
Registration Type	Permanent	Temporary	Seasonal - Winter
Date of Renewal			
Attendant Required			
Disability			
Mobility Aid			
Comments			

### SECTION A: APPLICANT INFORMATION AND SELF-EVALUATION

Please fill in all sections of this application form. Incomplete forms will not be processed. If a section does not apply, please write N/A (not applicable).

#### Type of Application:

New       Renewal      YATS ID Number (if known) \_\_\_\_\_

#### Applicant Information (PLEASE PRINT):

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Number                      Street                      Unit

Postal Code: \_\_\_\_\_

Pick-Up Address: \_\_\_\_\_  
(if different from mailing)      Number                      Street                                      Unit

Front or Back Entrance: \_\_\_\_\_

Telephone (daytime): \_\_\_\_\_

Telephone (evening): \_\_\_\_\_

Email: \_\_\_\_\_

Male       Female      Date of Birth: (month/day/year) \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs/kg

**Please provide the name of a person or agency (preferably local) that may be contacted in the event of an emergency:**

Name of Agency: \_\_\_\_\_

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone (daytime): \_\_\_\_\_ Telephone (evening): \_\_\_\_\_

Relationship to User: \_\_\_\_\_

**Travel Requirements:**

This section is intended to gather your travel information to assist with service planning. It will not be used to determine your eligibility.

Reason for using the service: (check all that apply)

Employment       Educational       Medical       Shopping

Recreational       Social

Other (please specify): \_\_\_\_\_

Estimated number of trips per week: \_\_\_\_\_

**Applicant Self-evaluation**

1. What is your disability?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. How does your disability affect your use of regular transit?

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3. Is the disability:

Temporary  Permanent  or Seasonal (Oct. 1 to April 30)?

If temporary, please provide an estimated duration (months) \_\_\_\_\_

4. Are you able to walk to the nearest bus stop from your home?

Yes  No  Sometimes  Not During Winter Months

If Sometimes, explain: \_\_\_\_\_

5. Are you able to board or disembark from a regular transit vehicle?

Yes  No  Sometimes

If Sometimes, explain: \_\_\_\_\_

6. Are you able to recognize your destination?

Yes  No  Sometimes

If Sometimes, explain: \_\_\_\_\_

7. Are you able to tell the driver your destination?

Yes  No  Sometimes

If Sometimes, explain: \_\_\_\_\_

8. Will you use any of the following items when you ride on YATS (check all that apply)?:

- |                                            |                                             |                                         |
|--------------------------------------------|---------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Powered wheelchair | <input type="checkbox"/> Power scooter  |
| <input type="checkbox"/> Portable Oxygen   | <input type="checkbox"/> Walker             | <input type="checkbox"/> Crutches       |
| <input type="checkbox"/> Cane              | <input type="checkbox"/> White cane         | <input type="checkbox"/> Service Animal |

Other (please specify) \_\_\_\_\_

9. Do you require an attendant to travel with you to assist you during the trip?

Yes

No

*Note: An attendant is required if you need help during your trip (getting ready to travel, while on board the bus, at your destination). Requiring someone to help you carry packages is a guest, not an attendant.*

**I hereby certify that the information given above is correct and give consent for the NWT Disabilities Council to pass this information on to the City of Yellowknife.**

Signature of Applicant: \_\_\_\_\_

Date: (month/day/year) \_\_\_\_\_

**I have received a copy of the YATS Service Guidelines and agree to adhere to the terms and conditions as set out.**

Signature of Applicant: \_\_\_\_\_

Date: (month/day/year) \_\_\_\_\_

**If you are not the applicant, but have completed this application on the applicant's behalf, please provide the following information:**

Name: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone (daytime): \_\_\_\_\_

Telephone (evening): \_\_\_\_\_

**I certify that to my best knowledge the information given above is correct.**

Signature: \_\_\_\_\_

Date: (month/day/year) \_\_\_\_\_

## **SECTION B: PROFESSIONAL EVALUATION**

This section may be completed by one of the following:

- ~ Licensed physician, physical therapist or nurse practitioner.
- ~ Rehabilitation specialist or occupational therapist.

### **Professional Evaluation – to be completed by applicant’s healthcare professional**

Please review the information in Section A provided by the applicant before you complete this section.

Patient’s Name: \_\_\_\_\_

1. I have read Section A in its entirety. Yes  No

2. I agree the information in Section A. Yes  No

If No, please explain: \_\_\_\_\_

3. In my opinion, the applicant is physically or functionally unable to use the regular transit service. Yes  No

4. In my opinion, the applicant will require the service:

Temporarily  Permanently  Seasonally  (Oct. 1 to Apr. 30)

If temporary, please provide an estimated duration (months) \_\_\_\_\_

**I hereby certify that the information given above is correct.**

Print Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: (month/day/year) \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Telephone: \_\_\_\_\_

### **Please return the completed application to:**

NWT Disabilities Council

Attn: Yellowknife Accessible Transit Application Process

Suite 116, 5102 50<sup>th</sup> Avenue

Yellowknife, NT, X1A 3S8

Applications can be faxed to 873-4124 or emailed to [admin@nwtcd.net](mailto:admin@nwtcd.net)

**For more information contact the NWT Disabilities Council**

Local: (867) 873-8230 Toll Free: 1-800-491-8885