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.

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):
Last Name: ____________________  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?

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

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)?:
   □ Manual wheelchair   □ Powered wheelchair   □ Power scooter
   □ Portable Oxygen   □ Walker   □ Crutches
   □ Cane   □ White cane   □ 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
B-321 Old Airport Road
Yellowknife, NT, X1A 3T3
Applications can be faxed to 873-4124

For more information contact the NWT Disabilities Council
Local: (867) 873-8230    Toll Free: 1-800-491-8885