

## 1 Eligibility Criteria

- A. Be a handicapped person, that is, “a person with a deficiency causing a significant and persistent disability (impairment), who is liable to encounter barriers in performing everyday activities”.
- B. Have mobility limitations that justify the use of paratransit services.

**Accordingly, a temporary limitation (for example, a broken leg) cannot qualify a person for paratransit eligibility.**

You can access the *Paratransit Eligibility Policy* on the website of the ministère des Transports at [www.mtq.gouv.qc.ca](http://www.mtq.gouv.qc.ca), under the heading “Persons with disabilities”.

## 2 Steps

- A. Part 1: To be filled out by the applicant.
- B. Part 2: To be completed **by a professional of the health care or education networks** who has access to the diagnosis of the applicant’s condition. Refer to the chart below.

### Motor or Organic Impairment:

- **For people who use a wheelchair permanently:**  
Doctor, occupational therapist, physical therapist, physiatrist, or physical rehabilitation therapist.
- **In all other cases:**  
Occupational therapist, physical therapist, physiatrist, or physical rehabilitation therapist.

**Intellectual Impairment:** Special needs professional, psychoeducator, psychologist, or social worker (if not registered in a CRDI).

**Visual Impairment:** Spatial orientation and mobility specialist or worker in rehabilitation for visually impaired.

**Psychological Impairment:** Occupational therapist, nurse, or social worker, all working in the field of psychological impairment.

### C. These documents are required for handling the form :

- Original form completed and signed.
- Proof of age (photocopy of the health card or birth certificate).
- One (1) recent passport-size photo identifying the applicant on the back.

*\* If documents are missing, the form will not be evaluated.*

The photo and proof of age can be transmitted electronically to [service.clientele@sts.qc.ca](mailto:service.clientele@sts.qc.ca)

Please send the documents to the following address:

**Société de transport de Sherbrooke  
Admission paratransit  
895, rue Cabana  
Sherbrooke (Québec) J1K 2M3**

**IMPORTANT : NO OTHER FORM MAY BE USED TO MAKE A VALID APPLICATION  
FOR PARATRANSIT ELIGIBILITY**

To be filled out by the eligibility officer

File number

Date of receipt of the application      Year      Month      Day

**Part 1 - General Information**

*An application is to be completed by the applicant, by a person designated by the applicant or by the applicant's legal representative, where the applicant is unable to act. Any incomplete or illegible application will be returned to the applicant, which delays processing of the application.* The confidentiality of the information conveyed will be maintained under the *Act respecting Access to documents held by public bodies and the Protection of personal information*. The information on the application is for the sole use of the eligibility committee.

**SECTION 1**

**Information on the applicant**

**PRINT (REQUIRED)**

Family name					First name						
Family name at birth (if different)											
Home address		No.		Street				Apt. No.			
Municipality								Postal Code			
Name of residential facility (if applicable)								Room No.			
<b>Telephone</b>		Area code		Number		<b>Work</b>		Area code		Number	Extension
Home											
<b>Cell</b>		Area code		Number		<b>Fax</b>		Area code		Number	
Cell											
Email address											
I agree to receive information or offers from my paratransit service provider <input type="checkbox"/> Yes <input type="checkbox"/> No											
Date of birth		Year		Month		Day		Gender		Weight	Height
								<input type="checkbox"/> Female <input type="checkbox"/> Male			
Language spoken		<input type="checkbox"/> French		<input type="checkbox"/> English		Other means of communication					
		<input type="checkbox"/> Other, specify: _____				Specify: _____					

**SECTION 2**

**Questions relating to paratransit eligibility and to the type of accompaniment.**

**1 Why are you applying for paratransit eligibility?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**2 Is there regular public transit service in your municipality?**

No  Yes ▶ If **yes**, are you able to use it?

No ▶ State the reasons for that inability. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Yes

Do not know

**3 If you are declared eligible for paratransit, will you need the help of someone on board the vehicle (example: for repositioning) during your trip?**

No  Yes ▶ If **yes**, what kind of assistance? \_\_\_\_\_

\_\_\_\_\_

**4 A. If you are declared eligible for paratransit, will you require the use of mobility aids during your trips on paratransit?**

No  Yes

**B. Specify the aid(s) required.**

Walker ▶  folding  non-folding  Three-wheeled scooter or four-wheeled scooter

Rolling walker  Wheelchair ▶  motorized

Cane ▶ Specify the type: \_\_\_\_\_  manual (rigid)

\_\_\_\_\_  manual (folding)

Crutches  Other ▶ Specify: \_\_\_\_\_

Guide dog or assistance dog (certified by a recognized school) \_\_\_\_\_

**C. Specify the aid that you will most frequently use:**

\_\_\_\_\_

\_\_\_\_\_

**D. Do you require bottled oxygen during your trips on paratransit?**

No  Yes

**5 Do you have dependent children under the age of 14?**

No  Yes ▶ State the name and date of birth of each.

Family name	First name	Date of birth
		Year      Month      Day
_____	_____	_ _ _   _ _   _ _
_____	_____	_ _ _   _ _   _ _
_____	_____	_ _ _   _ _   _ _

**SECTION 3**

**References and signature**

**1 Is there a professional other than the one completing the attestation of disability (Part 2 of the form) the eligibility committee could reach, if necessary, to facilitate the study of your application?**

Family name				First name			
Position				Name of facility (if any)			
Telephone		Area code	Number	Extension	Prof. licence No. (if any)		

**2 If the applicant is not the person completing this Part, give the name of the person who does so on his or her behalf.**

Family name				First name			
Telephone Home		Area code	Number	Work	Area code	Number	Extension
Cell		Area code	Number	Relationship to applicant			
Name of facility (if any)							

**3 Person to contact in case of emergency.**

Family name				First name			
Telephone Home		Area code	Number	Work	Area code	Number	Extension
Cell		Area code	Number	Relationship to applicant			
Name of facility (if any)							

**Applicant's authorization**

I certify that the information provided is accurate. I understand that a false statement could lead to the rejection of my eligibility application or the withdrawal of my paratransit eligibility. I hereby consent to have the eligibility committee review all the information provided on this form and in any supporting documents. I also authorize the committee to contact any person indicated in Question 1 of this Section, and the persons completing Part 2 of the form or any other attestation submitted with the application, for the purpose of validating the information conveyed or for obtaining further information, as required. I understand that, if I am declared eligible, only the information necessary for my travel, my safety and my comfort will be disclosed to paratransit service providers.

**Signature required**

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Signature of representative on behalf of applicant unable to act

\_\_\_\_\_  
Date (YYYY-MM-DD)

*You may append additional information in support of your eligibility or your paratransit needs.*

## Part 2 - Attestation of Disability (to be completed by a professional)

Please ensure that this part is properly filled out, otherwise processing of the application and access to paratransit service will be delayed.

### 1 A. What is the principal diagnosis on the applicant's record which causes mobility limitations?

Since when? \_\_\_\_\_

Check off and specify, if appropriate, the medical classification of the diagnosis in terms of functional impairment (level, class, stage):

- Intellectual disability ▶ level (mild, moderate, severe, profound) \_\_\_\_\_
- Respiratory deficiency ▶ class \_\_\_\_\_ / V
- Cardiac deficiency (New York Heart Association) ▶ class \_\_\_\_\_ / IV
- Parkinson's disease (Hoehn and Yahr Scale) ▶ stage \_\_\_\_\_ / V
- Traumatic brain injury ▶ level (mild, moderate, severe) \_\_\_\_\_
- Alzheimer's disease (Reisberg's Scale or Global Deterioration Scale [DAT]) ▶ stage \_\_\_\_\_ / 7
- Other ▶ Specify: \_\_\_\_\_

### B. Indicate any other diagnosis related to the need for paratransit service.

### 2 Does the applicant's condition allow foreseeing a possible recovery?

- No ▶ Explain: \_\_\_\_\_
- Yes ▶ Indicate the timeframe and explain:  within a year \_\_\_\_\_  
\_\_\_\_\_
- longer than a year \_\_\_\_\_  
\_\_\_\_\_

### 3 Does the applicant have one of the disabilities described below?

- No ▶ Go to Question 11.
- Yes ▶ Check off the applicant's limitations in one or more areas (eligibility criteria).
- 1. Walk 400 metres on even ground.
  - 2. Climb a step 35 cm high with support or descend without support.
  - 3. Make an entire trip using public transit because of extreme susceptibility to fatigue.
  - 4. Keep track of time.
  - 5. Find one's bearings.
  - 6. Master situations or behaviour that could compromise one's own safety or that of others.
  - 7. Communicate orally or through sign language. N.B.: this limitation alone cannot qualify the applicant for paratransit eligibility.

### 4 When do the disabilities indicated in Question 3 become apparent (if there is more than one disability, please write down the corresponding numbers from Question 3 in the appropriate boxes)?

- Throughout the year     Only in winter     Only after dusk
- Only when the applicant faces certain geographic obstacles. ▶ Specify: \_\_\_\_\_  
\_\_\_\_\_
- Only when the applicant travels with a dependent child under the age of 6.
- When the trip is unfamiliar, overly complex or involves a dangerous intersection.
- Only when the applicant travels for hemodialysis.
- In certain situations or intermittently ▶ Specify: \_\_\_\_\_  
\_\_\_\_\_

**5 Questions that are specific to certain impairments or disabilities: answer only those that are relevant.**

**A. Motor, neurological or internal organ impairment**

Specify, where appropriate, the type of functional assessment conducted and the result:

Berg scale (balance) \_\_\_\_\_

Other ► Specify: \_\_\_\_\_

**1) Ability to walk on even ground (specify)**

A) Maximum distance (in metres) that the person can cover \_\_\_\_\_

B) Time required to cover the distance \_\_\_\_\_

C) Condition of the person after walking this distance \_\_\_\_\_

**2) Ability to climb a step with support or descend without support (specify)**

A) Height of step the person can climb with support \_\_\_\_\_

B) Height the person can descend from without support \_\_\_\_\_

C) Limitation observed: range, muscular weakness, pain, balance \_\_\_\_\_

**3) Ability to take regular transit for a round trip**

A) At any time ► Explain: \_\_\_\_\_

B) Intermittently ► Explain: \_\_\_\_\_

**B. Visual deficiency (check off and specify)**

**Visual acuity:**

Far-sight vision with prescription lens (in metrics):

RE \_\_\_\_\_ LE \_\_\_\_\_ Both eyes \_\_\_\_\_

**Visual field:**

Under 20° ►  RE \_\_\_\_\_  LE \_\_\_\_\_

Over 20° ►  RE \_\_\_\_\_  LE \_\_\_\_\_

**C. Epilepsy**

Indicate if the condition is under control with medication:

No ► No medication succeeds in fully controlling seizures. Specify: \_\_\_\_\_

Yes \_\_\_\_\_

Partially under control ► Specify since when: \_\_\_\_\_

Give specifics on the nature of seizures (types and signs) and any side effects of medication (if applicable):

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

Do particular situations provoke seizures? Yes ► Specify: \_\_\_\_\_

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

If the person has severe seizures (with unconsciousness or convulsions), state how many times weekly on average these seizures occur:

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

If applicable, explain how the person's safety is compromised during travel: \_\_\_\_\_

\_\_\_\_\_

**D. Severe and persistent mental health problems (complete Section F also, if applicable)**

Are the person's disabilities controlled with medication?

No ► Specify: \_\_\_\_\_

Yes \_\_\_\_\_

**E. Cognitive disorders (complete Section F also, if applicable)**

Specify if the person has cognitive problems (e.g., understanding, judgment, memory).

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

**F. Behaviour problems**

In a transportation situation, could the person exhibit a behaviour problem (impulsiveness, aggressiveness, self-mutilation, runaway risk, etc.) that could be detrimental to his or her own safety or to that of other passengers, of which the carrier should be informed if the person is declared eligible for paratransit?

No

Yes ► Indicate the nature of the problem and how it manifests itself: \_\_\_\_\_

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

► Indicate the kind of situation that could lead to a transit-related behaviour problem: \_\_\_\_\_

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

**G. Communication problems**

Can the person communicate?

Verbally

Using signs

With major speech problems

Using gestures

No communication ► Specify: \_\_\_\_\_

Other ► Specify: \_\_\_\_\_

**6 A. Do the person's limitations require the use of one of the following mobility aids to facilitate travel on paratransit?**

None ► Go to Question 7.

Walker ►  folding  non-folding

Rolling walker

Cane ► Specify the type: \_\_\_\_\_

Crutches

Guide dog or assistance dog (certified by a recognized school)

Three-wheeled scooter or four-wheeled scooter

Wheelchair ►  motorized

manual (rigid)

manual (folding)

Other ► Specify: \_\_\_\_\_

**B. Must the person use this aid?**

All the time

Occasionally

Specify: \_\_\_\_\_

**C. Can the person using a manual wheelchair perform a self-transfer to the seat of a vehicle?**

No, even with someone's assistance

Yes, without help

Yes, with someone's assistance

**D. Does the person require bottled oxygen during paratransit travel?**

No

Yes

**7 If the applicant is declared eligible for paratransit, will the help of someone on board the vehicle be needed in light of the person's disabilities?**

No

No, not if certain measures are taken to alleviate behaviour problems during travel.

► Explain: \_\_\_\_\_

\_\_\_\_\_

Yes, temporarily during a period of familiarization of: \_\_\_\_\_

Yes, all the time. ► Reason: \_\_\_\_\_

\_\_\_\_\_

**8** Has the person been registered for a course in orientation and mobility, a learning or familiarization process (treatment or behaviour therapy), or to rehabilitation for the purpose of using regular public transit?

No, because:

The person does not have the potential. ► Explain: \_\_\_\_\_

The person has the potential, but there is no regular public transit in the municipality.

Other ► Specify: \_\_\_\_\_

Yes, supervised by: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name of facility: \_\_\_\_\_

Start date: \_\_\_\_\_ Probable duration: \_\_\_\_\_ End date: \_\_\_\_\_

If this initiative proved fruitless, explain the reasons:

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

**9** **A. Could the person use regular public transit for some travel without accompaniment?**

No ► Reason: \_\_\_\_\_

Yes, for all trips.

Yes, except in certain situations. ► Specify: \_\_\_\_\_

Yes, for certain particular trips. ► Specify the origin and destination of those trips:

**Origin**

**Destination**

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

**B. Could the person use regular public transit when accompanied?**

No ► Explain: \_\_\_\_\_

Yes

**10** The information contained in this document concerning the diagnosis and assessment of disabilities comes from:

An assessment of the applicant. ► Specify the type of assessment, if applicable: \_\_\_\_\_

The applicant's record:  Diagnosis ► Specify the date: \_\_\_\_\_

Assessment of disabilities ► Specify the date: \_\_\_\_\_

Other ► Specify: \_\_\_\_\_

**11** How long have you been treating or providing services to that person?

This form was filled out by:

Family name, first name: \_\_\_\_\_

Position: \_\_\_\_\_

Telephone: \_\_\_\_\_ Prof. licence No. (if any): \_\_\_\_\_

Stamp or seal of  
the professional  
or facility

Stamp or seal

I certify that the information provided on (indicate first and family name) Mr. \_\_\_\_\_ or

Ms. \_\_\_\_\_ is accurate. I understand that a false statement could lead to the rejection

of the applicant eligibility application or the withdrawal of paratransit eligibility.

\_\_\_\_\_  
Signature required

\_\_\_\_\_  
Date (YYYY-MM-DD)

*You may append additional information you deem necessary in support of this attestation.*

**THE CONTENT OF THIS FORM IS PRESCRIBED BY THE MINISTÈRE DES TRANSPORTS DU QUÉBEC.**