

ACCESSIBLE LOW FLOOR (ALF) PERSONAL CARE ATTENDANT REQUIREMENT FORM

Administration Use Only

Authorized by: _____

Date: _____

**Authorization for release of information to be completed by the applicant
or representative:**

I, _____, hereby authorize _____
(Client's Name) (Professional Care Provider)

**to release to Halifax Regional Municipality, Metro Transit, any
information with regard to my mobility which may be required to
establish the need for a personal care attendant when travelling on
Accessible Low Floor transit service.**

Signature of Applicant: _____

Applicant's Address: _____

Please return application to:

**Metro Transit
200 Ilsley Avenue
Dartmouth NS B3B 1V1
Phone: (902) 490-6681
Fax: (902) 490-6664**

Metro Transit Accessible Low Floor (ALF) Functional Assessment Form

TO BE COMPLETED AND SIGNED BY THE APPLICANT'S ATTENDING PROFESSIONAL CARE PROVIDER (PHYSICIAN, NURSE PRACTITIONER, OCCUPATIONAL THERAPIST, PHYSIOTHERAPIST)

Any fees associated with the completion of this form are the responsibility of the Applicant.

Use of Accessible Low Floor (ALF) transit service offers mobility-impaired customers greater freedom and flexibility when travelling in HRM. A Personal Care Attendant is **always** required to accompany the applicant while travelling on Metro Transit. Passengers who require attendants will have their attendant's fare included in their own, therefore there will be no extra cost for attendants with proper identification displayed by the customer.

Applicant's Name: _____

1. Please describe the applicant's functional impairment and how it inhibits their ability to travel on Metro Transit's Accessible Low Floor (ALF) fixed-route bus service **without an attendant**.

2. Does the client require the use of a mobility device?

Cane _____ Walker _____ Wheelchair _____ Scooter _____ Other _____

3. Can the applicant walk unassisted outside 175 Meters?

Yes _____ No _____

4. Is the applicant physically able to step up or down 3 – 4 steps that are 35 centimetres in height?

Yes _____ No _____

5. Does the applicant have the cognitive ability to learn fixed bus routes and schedules?

Yes _____ No _____

6. Does the applicant have the cognitive ability to make or alter transportation requests without the assistance of a caregiver?

Yes _____ No _____

7. For what period of time will the applicant require a Personal Care Attendant?

Temporary _____ Permanent _____

Professional's Signature _____ **Date** _____

Professional's Name (Please Print) _____ **Telephone** _____

Professional's Licence # _____