

## 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. **Also fill out the mobility aids annex.**

### 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.

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

- C. Send your completed application along **with two (2) recent pictures in passport size** identified on the back (pictures can be sent electronically at [transportadapte@stl.laval.qc.ca](mailto:transportadapte@stl.laval.qc.ca)) **and a proof of your age**<sup>1</sup> (photocopy of your birth certificate, passport, health insurance card or driver’s licence) to the following address:

**Société de transport de Laval**  
**Service de transport adapté**  
2250, avenue Francis-Hughes  
Laval (Québec) H7S 2C3

<sup>1</sup> Proof of age is required in the case of accompaniment services for parental duties, free services for young children and reduced rates for students and persons aged 65 and over.

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.																			
Telephone Home					Area code					Number					Work					Area code					Number					Extension				
Cell					Area code					Number					Fax					Area code					Number									
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?

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**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		Area code		Number				Work		Area code		Number				Extension			
Home																			
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		Area code		Number				Work		Area code		Number				Extension			
Home																			
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).

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### 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: \_\_\_\_\_

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

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### 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: \_\_\_\_\_

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

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

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**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.**





## Annex - Eligibility Form

**This annex must be filled by the healthcare professional**

### 1. Accessible regular transport network

The accessible regular transport network allows people in wheelchairs, three-wheel and four-wheel scooters, walker and other types of mobility aid, to use the regular STL network thanks to our buses equipped with access ramps. This service is designed for people who can get on and off the bus by themselves or with help of their companion. It does not replace the paratransit service which is still available for people who prefer it or for those who require more help.

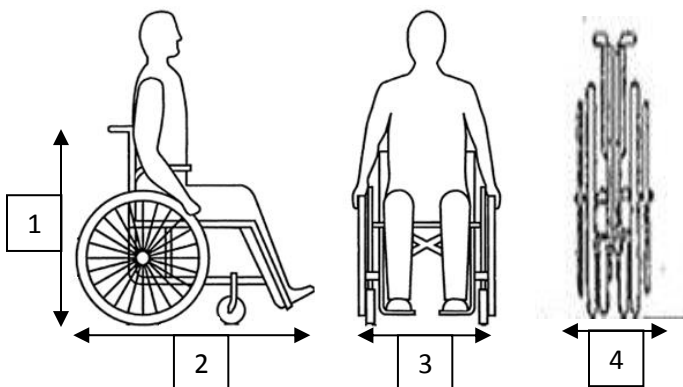
Would the person be capable to use the accessible regular transport network if such service was available.

- Yes ☐
- No ☐
- With companion ☐

### 2. Additional information for Mobility Aids

#### A. For wheelchair (motors or manual)

Model: \_\_\_\_\_



- 1) Maximum height: \_\_\_\_\_  
(From the floor to the highest point)
- 2) Length: \_\_\_\_\_
- 3) Overall width: \_\_\_\_\_  
(Maximum width of the wheelchair)
- 4) Folded: \_\_\_\_\_

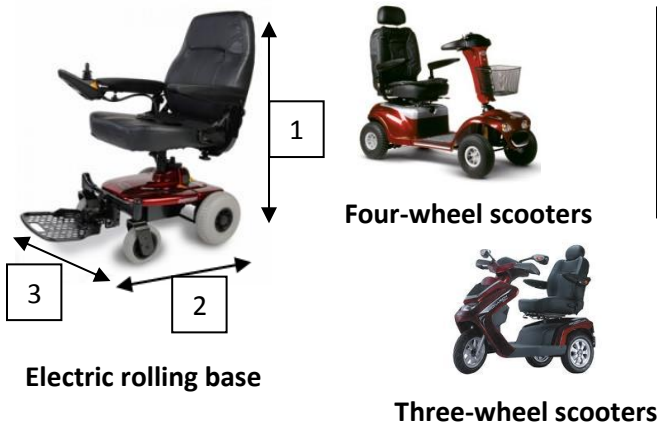
The maximum dimension of the wheelchair must not exceed 1372 mm (54 in.) long by 83 mm (33 in.) wide.

- The combined weight of the wheelchair and the user should not exceed 363 kg (800 pounds).
- The manual and motorized wheelchairs must be equipped with four (4) anchor points. (The "Compagnon type" must be folded.)



**B. For electric rolling base, three or four-wheel scooters**

Please note that you are REQUIRED to sit on the vehicle bench.



- |   |
|---|
| 1) Maximum height: _____<br>(From the floor to the highest point) |
| 2) Length: _____  |
| 3) Overall width: _____<br>(Maximum width of the wheelchair)      |

- Electric rolling base, four or three wheel scooters must be equipped with four (4) anchor points.

**C. For walkers and wheeled walkers**

Model: \_\_\_\_\_

Folding ☐ Non-folding ☐

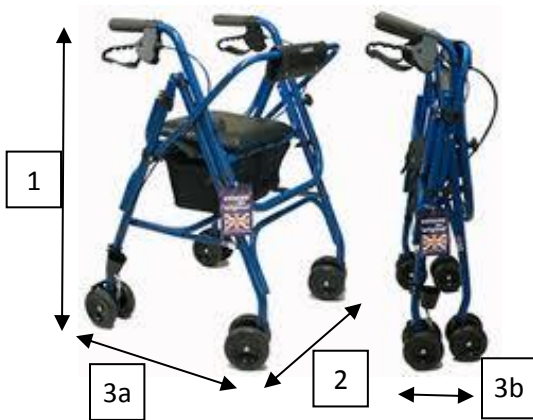
- |  |
|--|
| 1) Maximum height: _____<br>(From ground to handles) |
| 2) Overall width: _____<br>(Maximum width)           |
| 3a) Depth – non-folded: _____                        |
| 3b) Folded: _____                                    |



#### D. For the rollator

Model: \_\_\_\_\_

Folding ☐ Non-folding ☐



- 1) Maximum height: \_\_\_\_\_  
(From ground to handles)
- 2) Overall width: \_\_\_\_\_
- 3a) Depth – non-folded: \_\_\_\_\_
- 3b) Depth – folded: \_\_\_\_\_

- Ensure proper operation and cleanliness.
- The basket should be emptied to fold the rollator.

#### E. Adapted stroller

Model: \_\_\_\_\_

<ol style="list-style-type: none"> <li>1) Maximum height: _____ (From ground to the highest point)</li> <li>2) Overall width: _____</li> <li>3) Overall length: _____</li> </ol>
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- The adapted strollers must be equipped with four (4) anchor points.

Applicant's name : \_\_\_\_\_

Healthcare professional's name: \_\_\_\_\_

Title: \_\_\_\_\_

Date : \_\_\_\_\_