

ELIGIBILITY APPLICATION

Help us process your application in a timely manner. Any information that is not completed in the application could delay or prevent our ability to process your request for service.

- A) Have you completed all 3 Sections?
- B) Have you or the guardian signed at the bottom of this page?
- C) If you are a War Veteran or Silver Cross recipient have you included proof of status?

- PLEASE READ CAREFULLY -

- ◆ Physical disability/disease related circumstances are all contributing factors in the review of each application. Verification of disability by a Registered Health Care Professional does not establish approval. Consent is finalized by Operation Lift. Applicants' not approved for service may appeal.
- ◆ The personal information collected in this application will be used only for the purpose of releasing or obtaining information about my care and health status, or in emergency circumstances, as is deemed necessary in the use of the service. This information is protected under the Personal Health Information Protection Act (PHIP).
- ◆ Should you require this information in larger print or different format, please let us know and we will do our best to assist you. (AODA Reg. 429/07)

Applicant Declaration:

I certify that to the best of my knowledge, the information given is correct.

Applicant Signature: _____

Guardian or Authorized Signature: _____

Signature is
required prior
to service

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

Your Name: _____ Address: _____

Bus. Tel: _____ Res. Tel: _____ (where applicable)

Relationship to applicant: _____

Today's date: _____

IF SERVICE IS NEEDED WITHIN THE WEEK OF APPLYING, NOTE DATE AND TIME OF TRANSPORTATION REQUIRED:

DATE: _____ **TIME:** _____

HEALTHCARE SECTION

ATTENTION HEALTHCARE PROVIDERS – PLEASE VERIFY THE INFORMATION IN SECTION “B”

Service Criteria – Physically unable to:

- * go up or down stairs
- * walk 175 metres (575 feet)
- * unable to use conventional transit

LIFT MAXIMUMS:

700 lbs.		BE SURE – BE SAFE
50" long	}	Know your weight
30" wide		and fit!
**SERVICE CAN BE REFUSED IF		
MOBILITY DEVICE IS DEEMED UNSAFE**		

Applicant: _____

1. What is the applicant’s primary disability?

2. Does the Applicant pose a risk physically or psychologically to other passengers?
Yes _____ No _____ If ‘Yes’, please explain:

3. Does the Applicant have other medical conditions that prevent their use of conventional transit? If yes, please explain:

4. Can the Applicant be safely left alone at their drop off location without being handed over to the care of another person? Yes ___ No ___
5. For what time period is service required?
Temporary ___ Unconditional/Permanent ___ Conditional ___
(seasonal)



Designation Box
OFFICE USE ONLY

I verify the information to be true and correct.

Health Professional Name: _____ Profession: _____

Signature: _____ Tel: _____ Fax: _____

Operation Lift P.O. Box 452; 140 West Street
 Brantford ON N3T 5N9
 Tel: 519-756-2170 Fax: 519-756-2147

*Operation Lift is not responsible for any costs incurred for this application.
 Operation Lift reserves the right to review eligibility with
 attending Professionals and Applicant at any time.*