Client Referral Form
For CARE Transit Program

Eligibility Guidelines for CARE Transit Program

a. Live within the boundaries of the District of Hope, or Electoral District A or B.
b. Have no alternative transport available.
c. Referred to the Program by an agency, doctor, family, friend, school principle.
d. Able to provide appointment information (address, date and time)
e. Capable of giving the driver clear directions to your appointment
f. Ready and available for pick up at accessible location
g. Willing to share a drive where scheduling permits

Applicant Information (Please print clearly) **STRICTLY CONFIDENTIAL**

Last Name: .... First: .... Init: ....

Date of Birth: .... Gender ....
(mm / dd / yyyy)

Apt./Unit #: .... Address: .... Intercom #: ....

City: ....Prov: ....Postal Code: ....

Is this a permanent resident? ☐ **YES** ☐ **NO** (explain)
....
....

Resident Location Description (apartment, difficult location, etc.) ....
....

Mailing address if different from above
....
....

Phone: .... Fax: ....Cell: ....

Email ....

Preferred communication: ☐ Home phone ☐ Fax ☐ Cell ☐ Email

Information for transportation - Client: - **Please Check**

☐ Does not smoke ☐ Prefers no smoking car ☐ Requires no smoking car ☐ Prefers to smoke on ride

Needed and Provided by Client:

Accompany ☐ None ☐ Attendant ☐ Parent ☐ Child
Assistance ☐ No special requirements ☐ Needs ☐ To be transferred from wheelchair
Crutches ☐ None ☐ Crutches
Walker ☐ None ☐ Small folding ☐ Folding with seat ☐ Non-folding
Wheelchair ☐ None ☐ Folding ☐ Non-folding ☐ Electric wheelchair
Oxygen ☐ None ☐ Oxygen
Car Entrance Required: ☐ No special needs ☐ Prefers low entrance ☐
Driver gender request: ☐ Male only ☐ Prefers Male ☐ Either ☐ Female only ☐ Prefers Female
Funding Provided by Client: ☐ None ☐ Partial ☐ Full
Funding Provided by Referring Agency: ☐ None ☐ Partial ☐ Full

Any Medical conditions ....
....

Signature of Client: .... **Date**: ....

I ……………………………………………………authorize CARE Transit to determine the eligibility for authorized transportation and, if needed, to consult the agency representative, medical specialist, or family doctor named below. I understand and agree that the decision of CARE Transit shall be final.

Signature of Client: .... **Date**:.......................................

This section to be completed by the referring agency or person (*print clearly)*

Verification of Eligibility for CARE Transit Program

Please Note: Before completing this verification, refer to the eligibility guidelines. Has the applicant use of any alternative transportation?

☐ **YES:** explain ☐ **NO:**

....

....

Family Doctor: .... Phone: ....

☐ **This client needs person-to-person transfer**

Referred By: (agency or individual) ....

Position: ....Contact Person: ....

Address: .... City: ....

Postal Code: .... Telephone: ....Fax: ....

I .... *(Contact Person)* hereby verify that the above named applicant meets the eligibility criteria to register for the CARE Transit Program.

Signature .... Date ....

Signature of CARE Transit Coordinator: .... Date: ....

Privacy: We will never provide your personal information to any third party without your prior written approval.

Mail this form to: Box 1265, Hope BC V0X 1L0 or fax to 604 869 3397
For information phone: 604 869 3396