



9. Emergency Contacts: List two people we can contact in case of an emergency.

Name: _____	Name: _____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Cell Phone: _____	Cell Phone: _____
Relationship to applicant: _____	Relationship to applicant: _____
Pick up Address: _____ (If different than above)	Front of building: _____ Back of building: _____

10. Alternate Address: If there is nobody at your residence to meet you and you can not be left alone, you MUST provide an alternate address (preferably nearby) the driver can take you to.

Contact Name: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Do you live alone?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have a part-time caregiver?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have a full-time caregiver?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

11. Which primary mobility aid(s) do you use when traveling in the community: (check all that apply:)

<input type="checkbox"/>	None	<input type="checkbox"/>	Long White Cane	<input type="checkbox"/>	Powered Wheelchair **
<input type="checkbox"/>	Walking Cane	<input type="checkbox"/>	Crutches	<input type="checkbox"/>	Collapsible Walker **
<input type="checkbox"/>	Leg Braces	<input type="checkbox"/>	Interpreter/Intervener	<input type="checkbox"/>	Manual Wheelchair **
<input type="checkbox"/>	Service Animal	<input type="checkbox"/>	Hearing Aid	<input type="checkbox"/>	Scooter **
<input type="checkbox"/>	Personal Attendant	<input type="checkbox"/>	Oxygen Tank	<input type="checkbox"/>	Walker **
<input type="checkbox"/>	Communication Devices	<input type="checkbox"/>	Prosthesis	<input type="checkbox"/>	Other

\*\* Please provide outside dimensions:  
\_\_\_\_\_

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## Mandatory Attendant (MA)

A Mandatory Attendant (MA) may be assigned when a LATS Customer needs individual assistance on the vehicle due to a medical condition and/or behavioral concern. Mandatory attendant status will not be assigned to a Customer who needs assistance at their destination. Customers that are assigned **MA** are not able to book any trips for travel without a mandatory attendant (this applies to all trips).

Customers who require a mandatory attendant must request the designation prior to booking (at time of registration or by contacting LATS Administration as necessary). Mandatory attendants are not required to pay a fare.

Customers displaying unacceptable behavior that affects other passengers and/or the driver will be required to ride with an attendant at all times. Mandatory Attendant designation is for customers who require supervision ON the vehicle, not at their destination or to assist with parcels, etc.

If the customer cannot be left alone and no one is available when the vehicle arrives to receive the customer, the customer will have "mandatory attendant" status assigned by LATS Administration and they will have to ride with someone for all their trips.

To be completed by the Applicant – Senior home or apartment, living in a townhouse, duplex or house, etc.

Does your building have a name? (E.g. West Grove, Planeview Place, etc) \_\_\_\_\_

Where is the door you will be picked up from?

Front       Back       Side       Other  \_\_\_\_\_

Is there a buzzer code?    Yes  buzzer # \_\_\_\_\_    No

What is your room Telephone number? \_\_\_\_\_

	Yes	No	N/A
Do you have steps on the outside of your home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How many steps do you have? _____			
Can you manage the steps by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If you are in a wheelchair, do you have extra help to assist you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a ramp?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At your back door?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At your front door?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can snow/ice removal be a problem at the home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

All locations served by the LATS Operators must be accessible. Please confirm your destination is accessible and free of snow and ice for your requested pick up time. All locations must be kept free of snow and ice or we will not be able to provide service. Confirm that your destination is free of snow and ice before making a booking.

LATS Operators will provide assistance to and from the **first set of accessible doors** and with the securing of mobility aids and seatbelts.

If you use a wheelchair, can you transfer safely from the wheelchair into a van seat? Yes  No

Does your wheelchair fold up? Yes  No

Please ensure all mobility aids are in good repair. The LATS Operators must be able to secure your mobility aid or we may not be able to provide you with service. Wheelchair lifts measure 30" X 50" (76 cm X 127 cm). Equipment larger than this cannot be accommodated. The combined weight of the passenger and mobility aid must not exceed 750lbs.

**Is there any information the operator needs to know to provide safe transportation for you?**  
 (Please check all that apply):

Easily Confused/Wanders		May be aggressive	
Seizure disorder		Visually impaired	
Hearing impaired		Diabetes	
Use alternate form of communication		Cannot be left unattended	
Personal Attendant			
Communication Devices			

Other: \_\_\_\_\_

**If you are approved for the LATS, when do you require service?**

Summer only       Winter only       Full year

**If your service needs are temporary, how long do you anticipate needing the LATS?**

3 months       6 months       Full year       other  \_\_\_\_\_

**Please provide any additional information that may be relevant to this application:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**To be completed by the Applicant**

Indicate who completed this form. If you completed this form yourself, sign here:

I hereby declare that the information provided above is true and correctly represents my condition:

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

If someone else completed the form please indicate below.

(Advocate, guardian or health/social service practitioner completing the form for applicant)

Name (print): \_\_\_\_\_

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

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Professional Qualifications: \_\_\_\_\_

## Medical Information

### Consent Form

I agree that my doctor, nurse or other health worker may give information to LATS about my health concern or disability.

I agree that LATS may give personal information to my doctor, nurse, or health worker about my health concern or disability.

I will tell LATS if I no longer need door – to – door service.

I can:

- Ask to view or receive a copy of my personal information
- Withdraw consent for the release of my information to others, and
- Request correction to any of my information that I feel is in error

Name of Applicant (please print): \_\_\_\_\_

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

Parent or Legal Guardian name, if required: \_\_\_\_\_

Parent or Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This information is being collected under the authority of Section 33(c) of the Freedom of Information and Protection of Privacy Act ("FOIP Act") and will be used by the City of Leduc for processing this form and to determine eligibility for LATS. Information collected on this form may also be used by the City of Leduc for statistical, research or transit training purposes, to improve Special Transportation service. Personal information is protected by the privacy provisions of the FOIP Act. If you have any questions, contact the City of Leduc LATS Coordinator at (780) 980-7177.

## Professional Verification

### Part B: Health Assessment

**Part B: Health Assessment                      To be completed by a Qualified Health Care/Social Services Practitioner**

The purpose of this application is to provide sufficient information about the Applicant to allow FCSS staff to assess whether the Applicant is eligible for Leduc Assisted Transportation Service (LATS) and under what conditions.

Eligibility requirements include persons with disabilities and persons over the age of 65.

This form must be completed in full and signed by a qualified health care or social services practitioner familiar with the Applicant’s disability (i.e. medical doctor, register nurse, registered psychiatric nurse, occupational therapist, physical therapist, rehab practitioner, social worker).

**Charges for completing this form (or for obtaining additional information) are the responsibility of the Applicant.**

1. Applicant’s Name:

Surname	First Name	Middle Name
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2. Medical Status: Please describe the Applicant’s **current condition** that necessitates assistance with LATS.

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3. Please check type of disability:

Functional     Cognitive     Sensory     Seizure disorder     Other

Please provide details:

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4. Mandatory Attendant: LATS Operators must concentrate on the safe operation of their vehicle and the road conditions. The operators cannot supervise those who require constant or frequent attention due to medical or behavioral reasons.

In your opinion should the Applicant travel with an attendant? Yes  No

If yes, Please explain:

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

5. Can the Applicant be left alone at their destination? Yes  No

If yes, Please explain:

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

6. Does the Applicant's disability, health condition or equipment restrict his/her ability to wear a seatbelt during transportation? (If yes, this form **must** be completed by a Physician or surgeon).

This person should be seat belt exempt Yes  No

If yes, Please explain:

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

**Signature & Date** **To be completed by the Practitioner**

1. Name: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

2. Professional Qualifications: \_\_\_\_\_

3. Address: \_\_\_\_\_

4. Phone #: \_\_\_\_\_

5. How long have you or your agency been involved with the assessment of the Applicants health  
And/or physical condition? \_\_\_\_\_

I certify that I am currently a licensed health care practitioner under the Alberta Health Professions Act. I hereby declare that the information provided above is true and correct.

\_\_\_\_\_  
Practitioners Signature

\_\_\_\_\_  
Date

**Note:** Completed medical forms are to be returned to the applicant, and the applicant must then submit applications with parts A – B fully completed and signed. Applications will then be considered for approval. Incomplete application forms will be returned.

**By accepting the LATS Registration number, the registrant is agreeing to all of the terms and conditions of the use of the LATS.**

Please return completed Applications to:

Leduc Assisted Transportation Services  
#1 Alexandra Park  
Leduc, Alberta  
T9E 4C4  
(780) 980-7127 fax.

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