SIMCOE COUNTY LINX+ ACCESSIBLE TRANSIT

SUPPORT PERSON PASS APPLICATION

The Linx Plus Transit Support Person Pass identifies a person who, because of their disability, requires regular or occasional assistance while traveling on Linx Plus Transit buses. In compliance with the Accessibility for Ontarians with Disabilities Act (AODA), 2005, the Support Person Pass allows you to have one support person ride with you free of charge on any Linx+ Transit bus (or service route). There is no charge for the pass. Pass holders will be required to update their information and obtain a new card every three years.

The information obtained in this application process will be used by the County of Simcoe only to assess the applicant's eligibility for a support person pass. All information contained in the application will be kept confidential. Failure to complete this application in full will delay the application process.

If you have questions, need assistance or an alternate format, please call Service Simcoe at 1-800-263-3199.

How to Apply for Simcoe County Linx+

1. Complete Part A of this application.

2. Have your health-care professional complete Part B.

How to Submit the Application

Once the application is completed in full, mail, hand-deliver, fax or email the application to:

County of Simcoe
Attn. Transit Department
1110 Highway 26, Midhurst, ON L9X 1N6
Phone: 1-866-893-9300 ext. 1210
Fax: 705-727-4276
Email: transit@simcoe.ca

Eligibility

Eligibility for Simcoe County Linx Plus Support Pass is approved on the basis of three categories:

1. Unconditional – All trips require a support person in relation to, for example, a permanent disability.
2. Temporary – All trips require a support person for a limited duration, for example during recovery from surgery.
3. Conditional – Trips taken by a person with a disability who requires a support person under certain circumstances, such as extreme weather conditions.

Part A Personal Information

☐ New Pass ☐ Renewal Pass Office Use Only — Pass # _____

Name: _____

Date of Birth: _____

Address: _____ Apartment/Suite/Unit # _____

City/Town: _____ Postal Code: _____

Home Telephone: _____ Alternate Number: _____

Email: _____

I hereby authorize the undersigned heath care professional to release my personal information necessary to complete this application for the purpose of determining my eligibility for a support person pass.

_____ _____

Applicant's Signature Date

Part B Health Care Professional Information

Status of Condition (Check only one)

☐ Permanent ☐ Temporary

☐ Seasonal (December 1—March 1) Estimate Time in Months: _____

Health Care Professional Information

I am registered as:

☐ A licensed physician ☐ Certified psychologist/psychiatrist

☐ Registered occupational therapist ☐ Registered Nurse Practitioner

☐ Licensed Optometrist/Ophthalmologist/ ☐ Other: _____

Name: _____

Address: _____ Apartment/Suite/Unit #: _____

City/Town: _____ Postal Code: _____

Telephone: _____ Fax: _____

I hereby certify that the information provided is accurate and complete to the best of my knowledge.

_____ _____

Health Care Professional's Signature Date