WELLAND transit
GOING YOUR WAY

c/o Civic Square
60 East Main Street Welland, Ontario L3B 3X4
905-735-1700 ext. 2291 | transit@welland.ca
www.welland.ca/transit

Fax to: (905) 732-9422

Support Person Pass Application

PART A

In order to qualify for a support person pass, you must not be capable of traveling alone on the transit system. You must depend on their assistance to travel, and therefore will not be allowed to travel alone if a support person is not available for the trip.

The support person pass allows a passenger to have a support person ride with them at no charge. The passenger will still pay their fare; only the support person will ride free.

A support person is a person you choose. Welland Transit does not supply support persons. Your support person may be a different person each time, but only one support person can ride at a time. The support person must be able to provide any support that is needed.

A support person pass is accepted on conventional transit, as well as WellTrans.

How to apply:

1) Fill out Part B of the application. The information needed is of the passenger who requires the support person.
2) Have your doctor fill out Part C of the application.
3) Once filled out, send the application back to Welland Transit. Once it is approved, Welland Transit will call you. You will then be required to provide Welland Transit with a PASSPORT PHOTO of the applicant – Not the support person. (Note: Must be a passport photo to meet the criteria, measurements and clarity required to produce the pass. Passport photos can be purchased at Wal-Mart, Seaway Mall customer service, or Shoppers Drug Mart).
4) Until the applicant has the support person pass in their possession, they may still have an attendant ride with them, but the attendant will pay $3.00 per ride (each way) until the support person pass is received. The applicant will always pay for their trips, even when they have the support person pass.

Failure to complete this process properly will delay in receiving your support person pass.

You can mail your completed application to:
Welland Transit
c/o Civic Square
60 East Main Street
Welland, Ontario
L3B 3X4
If you have any questions, please call us at 905-735-1700 ext. 3101

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PART B – Applicant Information

Name: _____

Address: _____

Daytime Phone: _____ **Alternate Phone:** _____

1) **Please describe how your disability prevents you from using Welland Transit unaccompanied.**

_____

_____

_____

2) **Please describe the type of assistance your support person will need to provide during your transit trip.**

_____

_____

_____

I hereby certify to the best of my knowledge, the information given above is correct. I authorize the release of medical information to the City of Welland and Welland Transit. I consent to having Welland Transit health care authority discuss the contents of my application and eligibility for the support person pass with the health care professional that completed Part C of this application

_____ _____

Name of applicant or designate Date

_____

Signature of applicant or designate

Part C of this application must be filled out by a licensed physician

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PART C – Professional Certification

You are being asked by the applicant, named in Part B, to provide information regarding his/her ability to ride Welland Transit unaccompanied, and if they are safe to do so.

Please review Part A of the application form to understand the intent of the support person pass.

The information you provide will allow us to evaluate the request. If you have any questions, you may call Welland Transit at 905-735-1700 ext. 3101

1) **I have read part A in its entirety** Yes[ ] No [ ]

2) **In your professional opinion, does the applicant have a disability that requires him/her to travel with a support person on all trips?** Yes[ ] NO [ ]

   If yes, please describe in detail how the applicant's disability results in the requirement for a support person to travel with them while using Conventional and / or Specialized transit.

   _____
   _____
   _____
   _____

3) **In your professional opinion, does the applicant need the aid of a support person permanently [ ] or temporarily [ ]? If temporarily, please indicate the expected duration.**

   End date: _____

_____ _____
Signature of Health care Professional Date

_____ _____
Print Health care Professionals name Contact phone number

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