



ESSEX COMMUNITY SERVICES

35 Victoria Avenue, Unit 7

Essex, ON N8M 1M4

Phone: 519-776-4231 Fax: 519- 776-4966

TRANSPORTATION PROGRAM APPLICATION FORM

Full Name _____

Address _____
Street City Postal Code

Phone _____ Date of Birth _____
yyyy/ mm / dd

Language Spoken: English French Other _____

Language Preference: English French Other _____

1. Do you use? cane walker wheelchair

2. Can you go up or down 3 steps? yes no

3. Can you walk 1 block? yes no

4. Do you have a history of?

Arthritis

Seizures

Balance problems

Memory problems

Diabetes *

Heart condition

Deaf or hard of hearing

Vision problems

Mental health issues

High Blood Pressure

Dialysis Client *

* Dialysis Day(s): Mon Tue Wed Thu Fri

Appointment Length: _____ hours Start Time _____

5. Please describe any other health problems:

6. Please describe any mobility problems:

7. Please provide two emergency contacts:

1) _____
Name Relationship

Home Phone Work Phone

2) _____
Name Relationship

Home Phone Work Phone

8. Family doctor: _____
Name Phone

Signature _____ Date _____

For office use only:

Essex _____ Harrow _____ Aging @ Home _____

All applications will be reviewed to determine eligibility for this service

Funding is provided by
Ontario Ministry of Health and Long Term Care &
Local Health Integration Network (LHIN)