



Taxi Saver Program

Taxi Saver allows community members with permanent or temporary disabilities greater convenience for spontaneous travel throughout Mackenzie.

Eligibility

You are eligible for a Taxi Saver Program *HandyPass* if you meet all of the following criteria:

- You are a Mackenzie resident;
- You are between the ages of 18 and 54;
- You have a physical or mental disability; and
- You are considered in financial need based on Statistics Canada's low-income cut-off for populations less than 30,000.

To apply we ask for the following to be provided and forms completed:

- Application Form
- Proof of Age (ie. copy of your government issued photo ID)
- Completion of Disability Form (Schedule A of this document) signed by your physician or provide proof (e.g. disability cheque stub) that you are receiving assistance for, and have met the criteria of, a person with disabilities as defined under the *Employment and Assistance for Persons with Disabilities Act* and met the BCTransit HandyDart criteria.
- Self-declaration that you meet the current year's Statistics Canada Low Income Cut-Off for communities with a population of less than 30,000.

How it Works

Taxi Saver provides a 50% subsidy towards the cost of taxi rides. Eligible individuals purchase \$60 worth of Taxi Saver coupons for \$30. The purchaser uses the coupons to pay the dollar meter rate of taxi fare. For example, if a taxi fare is \$5.80, the passenger pays \$5.00 in coupons and 80 cents in change. Coupons cannot be used for tips. Taxi Saver coupons may be purchased during regular business hours at the Municipal Office.

Conditions of Use

Your *HandyPass* is not transferable to other individuals or other transit systems. The pass must be presented to the cab driver when paying the fare.



Taxi Saver Program Application Form

Name: _____

Phone: _____

Email: _____

Address (Include PO Box): _____

The following documentation has been provided as proof of eligibility for the Taxi Saver Program:

		Office Use (Type Provided)
<input type="checkbox"/>	Copy of government issued photo identification	
<input type="checkbox"/>	Copy of proof of primary residence in Mackenzie, BC	
<input type="checkbox"/>	Completed Schedule A – Disability Form, or other form of proof.	

Initial

I am self-declaring that my income meets the current year’s Statistics Canada Low Income Cut-Off for communities with a population of less than 30,000.

Initial

I confirm that I am applying for a non-transferable *HandyPass* for my own use and that I have read the above statements and confirm that they are true and correct to the best of my knowledge and belief.

Initial

I understand that the personal information on this form is collected by the District of Mackenzie for the purposes of Taxi Saver Program administration, under the authority of section 26(c) of the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection of information, please contact Director of Corporate Services, at 1 Mackenzie Boulevard, Mackenzie, BC, or by telephone 250-997-3221.

Applicant Signature: _____ **Date:** _____

Submit Application to:
District of Mackenzie
P.O. Bag 340, 1 Mackenzie Blvd., Mackenzie BC, V0J 2C0
Email: info@districtofmackenzie.ca



Schedule A

Proof of Disability Form

Mackenzie Taxi Saver Program is a special service for persons between the ages of 18 and 54 years who have a permanent or temporary disability which has been confirmed by a medical practitioner.

For a HandyPass you will be asked to have this Proof of Disability form signed by your physician, or provide proof (e.g. Disability cheque) that you are currently receiving assistance for, and have met the criteria of, a Person with Disabilities under the Employment and Assistance for Persons with Disabilities Act, and by meeting the criteria for BC Transit HandyDart.

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- (a) Proof of Disability (e.g. cheque stub) has been presented and criteria met. _____
OR
(b) Form to be completed by medical practitioner _____
-

I, _____ meet the criteria as noted on this form.

Medical Practitioner's Name: _____

Address: _____

City: _____ Province: _____

Postal Code: _____

Type of Disability: Permanent:
 Temporary: Date on which recovery is expected: _____

I hereby verify that _____ (name of applicant)
has a disability that meets the established criteria and that is sufficiently severe that he/she is eligible to
use the Taxi Saver Program.

Signature of Medical Practitioner

Date Signed