



VIA Metropolitan Transit

## **Information For VIAtrans Applicants**

**What is VIAtrans ?** **The Americans with Disabilities Act of 1990(ADA)** mandates that public entities operating a fixed route transportation system shall also provide, to persons with disabilities, a complementary paratransit service that is comparable to the level of service provided to individuals without disabilities who can use fixed-route bus service. Complementary paratransit is to be provided to those individuals whose impairment or disability prevents them from independently traveling by regular city bus. VIAtrans is a specialized transportation service available to most Bexar County residents who have a medical impairment or condition that prevents them from independently traveling by regular VIA city buses. VIAtrans service employs a variety of vehicles including vans and lift equipped vehicles to meet the customers' special travel needs. VIAtrans is a "curb-to-curb" shared-ride system comparable to regular city bus service. VIAtrans riders must be pre-registered to use the service and must make reservations at least twenty-four (24) hours in advance of their anticipated trip. VIAtrans riders may schedule trips for any purpose and, if pre-authorized, may travel with a personal care attendant. Minor children age six(6) and under are not eligible for VIAtrans paratransit service.

**Who can use VIAtrans?** VIAtrans service is provided within three-quarters mile of a fixed bus route to most Bexar County addresses with the exception of certain unincorporated areas within Bexar County. At this time, these areas include whole or portions of Helotes, Hill Country Village, Hollywood Park, Live Oak, Lytle, Schertz, Selma, Somerset, Universal City and Windcrest. VIAtrans is not permitted to pick up or drop off at addresses in these areas. Within the VIA service area, the base fare for one-way trip is \$1.75.

**If I have a disability, do I automatically qualify for VIAtrans Service?** All VIAtrans eligibility determinations are based on the paratransit criteria and guidelines set forth in the **Americans with Disabilities Act of 1990**. In keeping with ADA criteria, VIAtrans eligibility is not based on an individual's medical diagnosis but their functional ability to use regular city bus service. As part of the VIAtrans eligibility determination process, applicants may be asked to participate in physical functional assessment performed by a skilled trained professional therapist. The functional assessment is used to identify the applicant's special travel needs and accommodations for transit travel. The functional assessment performance report along with all available medical documentation and application information are reviewed by an VIA eligibility Specialist who will make the eligibility determination.

**How will I know if my application is approved?** Your VIAtrans application should be fully completed when submitted. Incomplete forms will be returned to you or your doctor, which may delay the eligibility determination process. As a part of the eligibility process, you may be requested to participate in a functional assessment to identify your special travel needs. Within 21 days of receipt of all required information, your complete record will be reviewed and an eligibility determination will be made. If you are found to be eligible for VIAtrans services, your eligibility notice will instruct you on how to obtain your Photo Identification Card and to activate your reservation record. At that time you will be given your personal VIAtrans identification card along with a comprehensive VIA Customer Guide. If you are found ineligible, you will be provided with instructions on the appellate process.

If you have questions about this application, please call the Accessible Services Department (210) 362-2140 between 8:00am to 4:45pm, Monday thru Friday. TDD calls may be made to (210) 362-2019 between 8:00am and 4:45pm, Monday thru Friday. Additional information available at **[www.viainfo.net](http://www.viainfo.net)**.

VIA Metro Center  
1021 San Pedro  
San Antonio, TX 78212  
362-2140 (TDD: 362-2019)  
Revised Apr 2011

<b>ID#</b> _____ For Office Use Only
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**ADA Cat** \_\_\_\_\_  
AWS \_\_\_\_\_  
EligTo \_\_\_\_\_  
DX \_\_\_\_\_

## **Application For VIAtrans Service**

**INSTRUCTIONS:** On pages 1, 2, 3 and 4 of this application, VIA is asking for information about you and your ability to use VIA bus service. Some questions are general and some are specific, but all are important. Please take the time to **answer ALL questions carefully and completely.** We cannot determine your eligibility for VIAtrans service without this information. It's all right for a friend, guardian, caregiver, agency service representative or family member to help you complete your portion of the application, specifically pages 1, 2, 3, and 4. He or she will need to provide accurate information about you, your medical impairment, and your functional capacity. If you receive assistance completing your application, the person assisting you must be identified on Page 4. Pages 5 and 6 must be completed and certified by a physician who is familiar with your impairment or condition. Please direct your questions to us at 362-2140.

**General Information - All information requested must be provided**

Have you ever applied for VIAtrans or a Reduced Fare Card? NO  YES  DATE? \_\_\_\_\_

Have you ever been approved for VIAtrans/issued a Reduced Fare Card? NO  YES  DATE? \_\_\_\_\_

Applicant's Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Residence Address: \_\_\_\_\_ Apt# \_\_\_\_\_

City \_\_\_\_\_, TX Zip Code: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

Facility Name And/Or Apartment Name: \_\_\_\_\_ Gate Code \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Phone: \_\_\_\_\_ Day Phone: \_\_\_\_\_

What communications format would be most appropriate for us to communicate with you?

English \_\_\_ Spanish \_\_\_ Braille \_\_\_ Audio Cassette \_\_\_ TDD \_\_\_ E-mail address \_\_\_\_\_

**\*\*\*INDIVIDUAL AND MOBILITY INFORMATION:**

What assistive device(s) do you use when traveling? (Please check any that apply).

- |                                            |                                                      |                                                 |
|--------------------------------------------|------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Support Cane      | <input type="checkbox"/> <b>Manual wheelchair*</b>   | <input type="checkbox"/> Trained service animal |
| <input type="checkbox"/> Crutches          | <input type="checkbox"/> <b>Electric wheelchair*</b> | <input type="checkbox"/> Communications device  |
| <input type="checkbox"/> Leg brace(s)      | <input type="checkbox"/> <b>Electric scooter*</b>    | <input type="checkbox"/> "White cane"           |
| <input type="checkbox"/> Aluminum "walker" | <input type="checkbox"/> Portable oxygen             | <input type="checkbox"/> None                   |
| <input type="checkbox"/> Other (describe): |                                                      |                                                 |

**\*\*\*If you travel by wheelchair or scooter, you must provide the following information about your device:**

- a. Type(wchr?,sctr?): \_\_\_\_\_ Brand Name: \_\_\_\_\_ Make and Model# \_\_\_\_\_
- b. Measurements : width ( outer wheel-to-wheel): \_\_\_\_\_" length(front-to-back) \_\_\_\_\_"
- c. Combined weight of occupied device (chair weight + applicant's weight) \_\_\_\_\_ lbs.
- d. Attachments or features i.e., leg extenders,etc. \_\_\_\_\_



- 1. Please tell us about the times when you can use the regular fixed-route bus service? (Examples: if short distance to bus stop; if bus has a wheelchair lift, in good weather)  
\_\_\_\_\_
- 2. What is the nearest street intersection to your home? (Example: Blanco & Basse):  
\_\_\_\_\_
- 3. Can you walk or use your wheelchair or assistive device(s) from your home to that intersection without help and without injuring yourself? \_\_\_Yes \_\_\_No
  - a. How many minutes would it take you? \_\_\_2 \_\_\_5 \_\_\_10 \_\_\_15 \_\_\_can't do it.
  - b. How much farther past the nearest intersection could you travel, without help or injury?  
\_\_\_four times as far \_\_\_three times as far \_\_\_twice as far \_\_\_no farther
- 4. Can you safely cross a street alone? \_\_\_Yes \_\_\_No
- 5. Can you find your way to a bus stop without getting lost, and wait at the stop for the bus to arrive?  
Yes\_\_\_ No\_\_\_ If no, please explain: \_\_\_\_\_
- 6. At a bus stop, how long can you stand and wait for a bus?  
\_\_\_15 minutes \_\_\_10 minutes \_\_\_5 minutes \_\_\_ Less than 5 minutes
- 7. Can you understand bus schedule information? \_\_\_Yes \_\_\_No
- 8. All buses have a "destination sign" in front, which shows the route name and number.
  - Can you read a bus destination sign? \_\_\_Yes \_\_\_No
  - Can you ask the driver where the bus is going? \_\_\_Yes \_\_\_No
  - Can you give or write a note to the driver? \_\_\_Yes \_\_\_No
  - Can you understand the driver's answer? \_\_\_Yes \_\_\_No

9. If you were on the bus, could you pay the fare by putting coins or tickets in the fare box, or by showing a pass to the bus driver?  Yes  No If no, explain: \_\_\_\_\_
10. If you were on the bus, could you recognize the place where you wanted to get off the bus? If "no", please explain: \_\_\_\_\_
11. Have you ever used the bus in San Antonio or another city?  Yes  No If "yes", please explain when and why you stopped using the bus?  
\_\_\_\_\_
12. Have you ever received "orientation and mobility training" or "travel training"?  Yes  No If "yes", please list any VIA bus routes on which you can travel:  
\_\_\_\_\_
13. Please tell us the reasons why you believe you **cannot** use VIA bus service for some or all trips, or how it is difficult for you to do so:  
\_\_\_\_\_
14. Do you participate in a work activity center or workshop?  Yes  No If "yes", which one? \_\_\_\_\_
15. Do you attend a daycare center or participate in a residential care or day treatment program?  Yes  No If yes, which one? \_\_\_\_\_
16. Do you receive dialysis treatment?  Yes  No If "yes", where do you receive it? How often and/or which regular days? \_\_\_\_\_
17. Do you reside at an assisted living facility or at a nursing home?  Yes  No If "yes", which one? \_\_\_\_\_
18. Are you a student attending school?  Yes  No If "yes", name of school: \_\_\_\_\_
19. Are you able to walk up and down three (3) steps (12" rise, with handrails)?  Yes  No
20. If you use a wheelchair/scooter, can you transfer yourself from the wheelchair/scooter to a passenger car?  Yes  No
21. If you use a wheelchair or scooter, does your residence have a ramp?  Yes  No If no ramp, how do you get your wheelchair/scooter to street/ground level?
22. Do you require someone to travel with you? \_\_\_\_\_ If "yes", please explain why:  
\_\_\_\_\_
23. Are you able to independently call and make or cancel trip reservations?  Yes  No
24. Can you wait independently alone at your residence and places to which you travel? If "no", explain: \_\_\_\_\_

**AGREEMENT AND AUTHORIZATION:**

I state that the information I have provided is true, accurate, and correct. I authorize the release of diagnostic and functional information as requested, to VIA for the sole purpose of making a determination regarding my eligibility for paratransit service (VIATrans) or for the Mobility Assistance Program Reduced Fare Card for the fixed route bus service, and understand that all personal and medical information will be kept confidential.

If requested, I agree to undergo a functional assessment of my mobility abilities and limitations for the purpose of making a determination regarding my eligibility for paratransit van service (VIATrans) or for the Mobility Assistance Program Reduced Fare Card for fixed route bus service. I understand that intentionally false or misleading information or refusal to undergo a functional assessment is grounds for a determination of ineligibility for VIA services and benefits.

If approved, I agree to follow the rules and guidelines established by VIA and to promptly inform VIA of any changes in my residence, phone number, and if applicable, my caregivers name and phone number; and any significant change in my condition that would affect my level of mobility. I understand that failure to follow proper procedures or cooperate with VIA staff; demonstrating illegal or disruptive behavior; or if my condition at any time poses a direct threat to the health or safety of others, such situations may result in either suspension and/or termination of service or benefits.

**APPLICANT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**If this application has been completed by someone other than the person requesting certification, that person must complete the following:**

Name \_\_\_\_\_

What is your relationship to applicant? \_\_\_\_\_

Mailing Address \_\_\_\_\_

Home Phone: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Signature \_\_\_\_\_ date \_\_\_\_\_

**STOP! Response to the remaining questions on this application must be provided by a licensed or certified health care provider who is familiar with your condition. DO NOT TAKE THE APPLICATION PAGES APART. Take the entire form to your provider so that the medical section may be completed and the complete form may be returned to VIA Accessible Services**

Thank you

**DIAGNOSTIC AND FUNCTIONAL INFORMATION (to be provided by your physician, physician's assistant, therapist, or other certified or licensed health care provider who is familiar with your condition.)**

Dear Provider:

**The Americans with Disabilities Act of 1990** requires VIA to provide paratransit service to individuals who, because of their medical condition or impairment, are prevented from using regular VIA city bus service for most trips. Age, economic status, and environmental conditions may not be considered 'medical' factors in the assessment of paratransit eligibility. The information requested of you in the following sections will be used to determine the applicant's VIAtans eligibility. It is important that all questions be answered completely and accurately to the best of your knowledge and in accordance with your records. If the information is incomplete or unclear, we may need to contact you for clarification. Thank you for your cooperation.

1. Please indicate date of your most recent examination of this applicant: \_\_\_\_\_
2. Based on your knowledge of the patient's condition, is the information provided on the previous pages a reasonable representation of his/her condition? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If "no", please explain \_\_\_\_\_
3. Please provide **formal medical diagnoses and/or diagnostic codes** to describe the applicant's primary impairments or disabling conditions:  
\_\_\_\_\_
4. **If vision impaired**, what is **best corrected acuity** (Snellen)? (R) \_\_\_\_\_ (L) \_\_\_\_\_  
**Field Restriction:** (R) \_\_\_\_\_ (L) \_\_\_\_\_ **Date of Testing:** \_\_\_\_\_
5. **If hearing impaired**, what is the degree of discrimination for conventional speech without hearing aid(s)? (R) \_\_\_\_\_ (L) \_\_\_\_\_ With hearing aid? (R) \_\_\_\_\_ (L) \_\_\_\_\_
6. **If cognitively impaired**, what is the most recently recorded **IQ** or **Performance Test Scores** and date of Testing? \_\_\_\_\_
7. **What was the onset date of these conditions? (month/year):** \_\_\_\_\_ **If temporary, what is a reasonably anticipated recovery date for independent travel?** \_\_\_\_\_
8. Can applicant travel independently from his/her house, to the sidewalk? \_\_\_\_\_ Yes \_\_\_\_\_ No.  
If "no" or "sometimes", please explain: \_\_\_\_\_
9. Assuming the use of a mobility aid, if applicable, and with no major barriers in his/her path, how far can the applicant **independently** travel without help or significant risk of injury:  
less than 1/4 mile \_\_\_\_ 1/4 mile \_\_\_\_ 1/2 mile \_\_\_\_ 3/4 mile \_\_\_\_ more than 3/4 mile \_\_\_\_\_
10. Does the applicant's disability **require** him/her to travel with another person who provides personal assistance? Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes \_\_\_\_\_
11. Could the applicant benefit from travel training, if it was available? Yes \_\_\_\_ No \_\_\_\_ Maybe \_\_\_\_

**12. Please rate (Excellent / Good / Fair / Poor / None / Don't Know) the applicant in terms of:**

- a) upper body strength:    \_\_E   \_\_G   \_\_F   \_\_P   \_\_N   \_\_DK
- b) lower body strength:   \_\_E   \_\_G   \_\_F   \_\_P   \_\_N   \_\_DK
- c) coordination:        \_\_E   \_\_G   \_\_F   \_\_P   \_\_N   \_\_DK
- d) balance:             \_\_E   \_\_G   \_\_F   \_\_P   \_\_N   \_\_DK
- e) safety awareness:    \_\_E   \_\_G   \_\_F   \_\_P   \_\_N   \_\_DK
- f) independent judgment: \_\_E   \_\_G   \_\_F   \_\_P   \_\_N   \_\_DK
- g) sense of direction:   \_\_E   \_\_G   \_\_F   \_\_P   \_\_N   \_\_DK
- h) ability to understand  
and follow instructions: \_\_E   \_\_G   \_\_F   \_\_P   \_\_N   \_\_DK
- l) verbal communication: \_\_E   \_\_G   \_\_F   \_\_P   \_\_N   \_\_DK
- j) written communication: \_\_E   \_\_G   \_\_F   \_\_P   \_\_N   \_\_DK
- k) stamina and endurance: \_\_E   \_\_G   \_\_F   \_\_P   \_\_N   \_\_DK

**13. Is applicant wheelchair dependent?**   Yes \_\_\_\_\_   No \_\_\_\_\_

**14. What, if any, is the extent of left and/ or right-side paralysis:** \_\_\_\_\_

**15. Can the applicant walk up and down two steps (12" rise, each step, with handrails available)?**  
Yes \_\_\_\_\_   No \_\_\_\_\_   Sometimes \_\_\_\_\_

Does the applicant require a lift-equipped vehicle to board?   Yes \_\_\_\_\_   No \_\_\_\_\_

**16. Please list any other factors (i.e., extreme temperatures) which significantly restrict the applicant's mobility:** \_\_\_\_\_

**CERTIFICATION:**

I certify that the information I have provided hereto is a fair representation of this applicant's medical impairment or condition and is accurate to the best of my knowledge. I understand that the information provided hereto will be used for the sole purpose of determining the applicant's eligibility for paratransit services. I also agree that VIA may contact me for clarification of any information I have provided and that I will reply in good faith.

**Provider's Full Name:** \_\_\_\_\_

**Institution/Facility/AgencyName:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_ **Suite#** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Medical License Number:** \_\_\_\_\_ **Telephone#** \_\_\_\_\_ **FAX#** \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\*\*\* Note: "Stamped" signatures in the certification section will not be accepted.**