



VIA Metropolitan Transit
1021 San Pedro
San Antonio, Texas 78212
(210) 362-2140
TDD (210) 362-2019
Rev 10/2011

APPLICATION FOR VIA REDUCED FARE BUS CARD



Instructions: If you are a senior citizen age 62 years of age or older, a Medicare recipient, or a veteran with a VA disability rating of 100%, you do not need to complete this application. Please call the VIA Customer Service Center at 362-2020 for specific information on how and where to obtain your VIA Reduced Fare Bus card. You may also find Reduced Fare card information on our website at www.VIAinfo.net. If you are not included in these groups but have a disability or impairment that may qualify you for a Reduced Fare Bus card, you will need to complete the following information:

Please answer all questions carefully and completely. You may ask a friend, guardian, caregiver, agency service representative or family member to help you complete your portion of the application, specifically pages 1 and 2. If you receive assistance completing your application, the person assisting you must be identified on Page 2. Pages 3 & 4 of your application must be completed and a licensed or certified health care provider who is familiar with your current medical condition(s).

General Information:

Applicant's Name: _____ Date of Birth: ____ / ____ / ____
Medicare# _____ Medicaid# _____ Sex: M ____ F ____
Mailing Address: _____ City _____ State _____ Zip Code _____
Home tele#: _____ Day tele#: _____ Cell tele#: _____ email: _____

Disability and Mobility Information:

1. Describe your medical condition or impairment and how it affects your ability to travel by regular city bus: _____

2. Are you presently able to travel by city bus for *some* trips? Yes _____ No _____
If "no", explain: _____
3. Do you require assistive devices like a wheelchair, support cane, walker, crutches?
Yes _____ No _____ If "Yes", please describe: _____

4. Can you recognize your bus number and bus stop? Yes___ No___ Sometimes___
If "No" or "Sometimes", please explain:

5. Can you understand bus schedule information: Yes___ No___ Sometimes___
If you answered "No" or "Sometimes", please explain:

6. Can you get to and/or from the bus stop(s)? Yes___ No___ Sometimes___
If "No" or "Sometimes", please explain: _____
7. Can you use the bus steps or the lift to board or de-board? Yes ___ No__ Sometimes___
If "No" or "Sometimes", please explain: _____
8. How long can you stand and wait for a bus:
Not at all ___ 1 or 2 minutes___ 5 minutes___ 10 minutes ___ 15 minutes ___
If less than 15 minutes, please explain: _____
9. Do you require an escort, personal care attendant, or provider to travel by city bus?
Yes__ No ___ Sometimes___ If "Yes" or "sometimes", please explain:

10. Do you attend a Day treatment Center or Activities Workshop? If yes, please provide
facility name, address, and your attendance schedule:

11. Do you live at home under supervision or in an Assisted Living Facility? If yes, describe:

AUTHORIZATION AND AGREEMENT:

I agree that the information I have provided is true, accurate, and correct to the best of my knowledge. I authorize the release of diagnostic and functional information to VIA as requested for the sole purpose of making a determination regarding my eligibility for Reduced Bus Fare. I understand that all personal and medical information will be kept confidential. If approved, I agree to follow the rules and guidelines established by VIA. I understand that if I am approved for Reduced Bus Fare, and if the privileges and benefits of the Reduced Fare Card are abused or misrepresented in any way, my card may be confiscated and my eligibility terminated.

Applicant's Signature _____ Date: _____

If completed by someone other than the applicant, please complete the following information:

Completed by : _____ Relationship to Applicant _____

Mailing Address: _____ Day Tele# _____

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

THIS SECTION TO BE COMPLETED BY A LICENSED OR CERTIFIED HEALTH CARE PROVIDER WHO IS FAMILIAR WITH THE APPLICANT'S CONDITIONS, IMPAIRMENTS, OR DISABILITIES:

The applicant identified on Page 1 is applying for a VIA Reduced Fare Bus Card. The Americans with Disabilities Act of 1990(ADA) provides that Reduced Fare for city bus travel may be made available to persons who, due to illness, injury, age, congenital malfunction, or other permanent or temporary disabilities are unable to effectively utilize fixed route city bus service without special assistance or accommodation. To help us determine the applicant's current functional status please provide the following information:

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:
Diagnoses: _____
 - a. **If vision impaired**, what is **best corrected acuity** (Snellen)? (R) _____ (L) _____
Field Restrictions: (R) _____ (L) _____ Date of Testing: _____

 - b. **If hearing impaired**, what is the degree of conversational **speech discrimination** for without hearing aid(s)? (R) _____ (L) _____ With hearing aid(s)? (R) _____ (L) _____

 - c. **If cognitively impaired**, what is the approximate **IQ, mental age**, or functional level i.e., IQ greater or less than **70** or Mental age greater or less than **6 yrs.** _____

 - d. **If psychiatrically impaired**, does applicant:
 - Live in a boarding home or half-way house? Yes _____ No _____
If "yes", identify house manager and address: _____
 - Live at home under supervision? Yes _____ No _____
 - Attend in a Day Treatment Program? Yes _____ No _____
If "yes", identify name and address: _____
 - Participate in a work activity center or workshop? Yes _____ No _____
If "yes", identify name and address: _____

4. What was the **onset date** of these conditions? (month/year): _____ If temporary, what is a reasonably anticipated **recovery date** for independent travel? _____

5. Can applicant independently negotiate paths to and /or from a regular city bus stop?
Yes _ No ____ . If "no" or "sometimes", please explain: _____

6. How far can the applicant independently ambulate without assistance or significant risk of injury:
less than 1/4 mile ____ 1/4 mile ____ 1/2 mile ____ 3/4 mile ____ more than 3/4 mile ____

7. Approximately how long can the applicant stand and wait at a bus stop?
None at all ____ 1 or 2 minutes ____ 5 minutes ____ 10 minutes ____ 15 minutes ____

8. Does the applicant require a personal care attendant or provider to travel by city bus?
Yes _____ No _____ Sometimes _____

9. 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 _____

10. 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 & follow instructions: __E __G __F __P __N __DK
- i. verbal communication: __E __G __F __P __N __DK
- j. written communication: __E __G __F __P __N __DK
- k. stamina & endurance: __E __G __F __P __N __DK

11. Please list any other factors (i.e., extreme temperatures) which significantly restrict the applicant's mobility: _____

HEALTH CARE PROVIDER'S 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 a VIA Reduced Fare Bus Card. 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: _____

Mailing Address: _____ Suite# _____ City: _____ Zip Code _____

Medical License Number: _____ Telephone# _____ FAX# _____

Provider's Signature: _____ Date: _____

****Note: Faxed, Copied, Or Stamped Health Care Provider Signatures Will Not Be Processed