QUESTIONS & ANSWERS

WHAT IS VIAtrans?

VIAtrans is a shared-ride, curb-to-curb transportation service for people with a disability. Trips are available for any purpose and reservations must be made at least one day in advance. VIAtrans uses small vans that operate in the same areas and times as bus service is available. Van operators help passengers on and off vehicles but do not provide medical assistance or emergency service. The current fare is $2.00 per one-way trip.

WHO IS ELIGIBLE?

Applicants must be at least 6 years old. People who qualify are substantially limited in the performance of at least one major life activity. (This is the basic definition of "disability.") In addition, their limitations must prevent independent use of VIA bus service for some or all trips. An application must be completed and approved before VIAtrans service is provided. Eligibility is not based on age, income, residency or whether an applicant can drive a car.

HOW TO APPLY

The first step is to fill out pages 1-5 of the application as completely and accurately as possible. A friend or family member may assist. Then have a medical professional who is familiar with the applicant's condition complete pages 6 – 8. Please do not change or add to this information. Then mail or deliver the application to VIA (see next page) for processing.

WHAT HAPPENS NEXT?

VIA staff will conduct an eligibility review based on information from the application and, at times, the results of an in-person functional assessment of mobility skills. This process is based on the Americans with Disabilities Act (ADA) standards and requirements. In some situations, the functional assessment can be waived. Once all required information has been obtained, an eligibility decision will be made within 21 days. Applicants who meet eligibility requirements are approved for either unconditional service (all trips) or conditional service (some trips). Terms of eligibility range from three months to three years depending on the degree of disability

Applicants will be notified by mail if they are approved or denied eligibility. Approved applicants go to the VIA main office for a photo identification card and a brief orientation to the VIAtrans program. An appeals process is available to any applicant who disagrees with VIA's eligibility decision.

--- continued on other side ---

ADDITIONAL INFORMATON

For details about VIAtrans policies and procedures, please consult the *VIAtrans Service Customer Guide* or view the *Welcome to VIAtrans* video. Both are available at the www.viainfo.net. If you have questions, please contact the VIA Accessible Services Department at 210-362-2140 on weekdays between 8:30 a.m. and 4:30 p.m.

TO SUBMIT A VIAtrans APPLICATION

- Submit original applications only – no copies or faxes.
- Pages 6 – 8 must be completed only by a doctor or other medical professional.
- Submit the application to the following address:

  Accessible Services Department
  VIA Metro Transit
  1021 San Pedro Avenue
  San Antonio, TX 78212

- Medical facilities may email scanned originals, in color, to access@viainfo.net.
- VIA does not charge a fee for the VIAtrans application process.

SECTION I

VIAtrans APPLICATION

APPLICANT INFORMATION

Office Use Only

PRINT

○ M

○ F

Last Name *First Name* *Initial* *DOB*

Home Address *Unit* *City* *State* *ZIP*

Mailing Address *Unit* *City* *State* *ZIP*

Closest Intersection to Home (example: San Pedro & Hildebrand) *Gate Code*

( ) — ( ) —

Primary Telephone *Secondary Telephone* *Email*

○ *English* ○ *Spanish* ○ *Other*

Language Preferences *Occupation* *Hrs Per Week*

○ Standard Print ○ Large Print ○ Braille ○ Email ○ Other

Preferred Format *Level of Education*

Assistive Devices Used

○ *None* ○ *Manual Wheelchair* ○ *Electric Wheelchair* ○ *Scooter* ○ *Walker* ○ *Leg Brace* ○ *Back Brace*

○ *Neck Brace* ○ *White Cane* ○ *Walking Cane* ○ *Oxygen* ○ *Service Animal* ○ *Communication Device*

○ *Other:*

( ) —

Emergency Contact Person *Telephone* *Relationship*

COMMENTS:

OFFICE USE ONLY

Applicant's Last Name

SECTION I

APPLICANT INFORMATION

	Can you do the following tasks?	Circle answer	Describe difficulties you have performing each task. If no problems, enter *NA*. DO NOT LEAVE BLANK
1	SEE	Y N	
2	HEAR	Y N	
3	TALK	Y N	
4	READ & WRITE	Y N	
5	UNDERSTAND INFORMATION	Y N	
6	TELL TIME	Y N	
7	USE THE TELEPHONE	Y N	
8	PLAN & SCHEDULE TRIPS	Y N	
9	REMEMBER INFORMATION	Y N	
10	WALK	Y N	
11	CROSS STREETS	Y N	
12	STAND & WAIT	Y N	
13	STEP UP & DOWN A 12 IN. STEP	Y N	
14	COUNT & HANDLE MONEY	Y N	
15	INTERACT WITH OTHERS	Y N	

SECTION I

APPLICANT INFORMATION

PLEASE RESPOND TO EACH ITEM. IF NOT APPLICABLE, ENTER *NA*.

1	WHAT METHODS OF TRANSPORTATION DO YOU CURRENTLY USE?	
2	HOW MANY TIMES A MONTH DO YOU RIDE THE BUS?	
3	IF YOU RECEIVE DIALYSIS TREATMENT , ENTER THE NAME OF THE FACILITY AND TELEPHONE NUMBER.	
4	IF YOU LIVE IN A NURSING HOME OR ASSISTED LIVING FACILITY, ENTER THE NAME AND TELEPHONE NUMBER.	
5	IF YOU ATTEND AN ACTIVITY CENTER OR DAY PROGRAM, ENTER THE NAME AND TELEPHONE NUMBER.	
6	HOW OFTEN DO YOU USE A WHEELCHAIR OR SCOOTER — ALWAYS, SOMETIMES, OR NEVER?	
7	IF YOU NEED A FRIEND OR ASSISTANT TO TRAVEL WITH YOU, DESCRIBE THE ASSISTANCE THAT PERSON PROVIDES. PLEASE BE SPECIFIC.	
8	IF YOU TRAVEL WITH A SERVICE ANIMAL, LIST WHAT TYPE AND DESCRIBE HOW IT HELPS YOU.	
9	EXPLAIN IN DETAIL HOW YOUR DISABILITY PREVENTS YOU FROM RIDING THE BUS. PLEASE BE SPECIFIC. YOUR ANSWER TO THIS QUESTION IS VERY IMPORTANT.	

SECTION I

APPLICANT INFORMATION

PROVIDING THIS INFORMATION WILL SPEED UP PROCESSING TIME

If you have cancer, enter the complete name and contact information for your oncologist.

Name	
Address	
Telephone	

If you have COPD or emphysema, enter the complete name and contact information for your pulmonologist.

Name	
Address	
Telephone	

If you have seizures, epilepsy, traumatic brain injury, or any neurological disorder or disease, enter the complete name and contact information for your neurologist.

Name	
Address	
Telephone	

If you have a visual impairment that adversely affects your abilities (even with correction), enter the complete name and contact information for your ophthalmologist.

Name	
Address	
Telephone	

If you have schizophrenia, schizoaffective disorder, major depressive disorder, or other psychiatric diagnoses, enter the complete name and contact information for your psychiatrist, psychologist, mental health counselor, or mental health social worker.

Name	
Address	
Telephone	

Applicant's Last Name

SECTION I

APPLICANT INFORMATION

If you are being treated by a professional not cited on page 4, such as a rehabilitation doctor or any other medical specialist, enter the name, contact information, and area of specialty.

Name	
Address	
Telephone	
Specialty	

AUTHORIZATION SIGNATURE

By signing below, the applicant certifies that all information entered above is correct; acknowledges that providing false or incomplete information may result in eligibility being denied or terminated; authorizes VIA Metropolitan Transit to obtain information as it sees necessary from individuals whose names are provided by the applicant or applicant's representative; and acknowledges that all information will remain confidential and used solely to determine eligibility. (If the applicant is under eighteen years old, the applicant's parent, guardian, or representative possessing legal right to authorize the release of information must sign, thereby acknowledging and agreeing to the above terms and conditions.) Applications without appropriate signatures will not be processed. Before signing, please review all responses on the preceding pages, leaving no items blank and, where instructed, ensuring that *NA* is entered for all items that do not apply to you. Make no entries after this page. Leave pages 6, 7, and 8 blank for your medical professional to complete.

APPLICATIONS WITH MISSING OR INCOMPLETE RESPONSES WILL NOT BE PROCESSED.

Applicant's Signature | *Parent or Guardian's Signature (if applicant is under 18 yrs.)* | *Date*

If someone other than the applicant completed any part of Section I, please have that person sign below and enter requested information.

Print Name | *Signature* | *Relationship*

Address / City / State / ZIP | ***Phone***

DO NOT MAKE ENTRIES AFTER THIS PAGE

TAKE THE APPLICATION TO YOUR MEDICAL PROFESSIONAL

Applicant's Last Name

SECTION II

TO BE COMPLETED BY A DOCTOR OR SPECIALIST PROVIDING TREATMENT

APPLICANT: DO NOT MAKE ENTRIES ON THIS PAGE

Medical Professional: Please do not complete any part of this application if pages 6, 7, or 8 have entries when delivered to your office. If corrections are required, please initial and enter explanations as needed. Heavily edited applications will not be processed. Please leave no items blank and enter ***NA*** if not applicable or ***DK*** if you do not know the requested information. Thank you in advance for your input.

1	Approximately how long has the applicant been your patient?	
2	What is the primary reason the applicant cannot use the public bus system?	
3	List assistive devices *required* for mobility.	
4	What is the applicant's height and weight.?	
5	If visually impaired, what are the applicant's (corrected) visual acuities (Snellen)?	*R* *L*
6	If visually impaired, what are the applicant's field restrictions?	*R* *L*
7	If pending surgery, enter type, approximate date, and estimated recovery time.	

HEALTH RISKS DURING FUNCTIONAL ASSESSMENT

The applicant may be asked to participate in a functional assessment, during which assistive devices may be used and rest breaks taken as desired. For each task below, please indicate if participation poses a likely health risk. If a task is unsafe, briefly describe the potential risk. If the task does not apply to the applicant, enter **NA.**

	TASK	SAFE	UNSAFE	IF UNSAFE, WHY?
A	*Ascending and descending one 12-inch step with handrails*			
B	*Walking 2,640 feet on various terrains in various weather conditions*			
C	*If using a wheelchair or scooter, traveling without assistance on various terrains in various weather conditions*			

Applicant's Last Name

SECTION II

TO BE COMPLETED BY DOCTOR / SPECIALIST

APPLICANT: DO NOT MAKE ENTRIES ON THIS PAGE

FOR EACH ABILITY BELOW , INDICATE THE DEGREE OF LIMITATION RESULTING FROM THE APPLICANT'S DISABILITY.

	ABILITIES	NO LIMITATION	SLIGHT LIMITATION	MODERATE LIMITATION	SEVERE LIMITATION	DO NOT KNOW	NOTES
1	Walking						
2	Standing						
3	Stepping Up & Down						
4	Communicating						
5	Remembering						
6	Planning						
7	Interacting with Others						
8	OTHER:						

IN THE SPACES BELOW ENTER ICD-10 CODES FOR EACH DIAGNOSIS THAT IDENTIFIES THE APPLICANT'S PHYSICAL OR MENTAL DISABILITY.

IF A DIAGNOSIS IS TEMPORARY, ENTER THE ESTIMATED NUMBER OF MONTHS UNTIL RECOVERY. IF NOT TEMPORARY, ENTER NA.

ICD-10 CODES	MOS. TIL RECOVERY	ICD-10 CODES	MOS. TIL RECOVERY	ICD-10 CODES	MOS. TIL RECOVERY

COMMENTS

Applicant's Last Name

SECTION II

TO BE COMPLETED BY DOCTOR / SPECIALIST

APPLICANT: DO NOT MAKE ENTRIES ON THIS PAGE

Please cite any further medical, cognitive, or behavioral considerations that may impact the applicant's ability to use the public bus system.

PRINT

Medical Professional's Name | *Title* | *License Number*

Facility / Organization Name | *Specialty #1* | *Specialty #2*

Address / Unit. No. | *City* | *State* | *ZIP*

Telephone | *FAX* | *Email (optional)*

I certify the information I provided is accurate to the best of my knowledge and that no entries were made in the medical section prior to receiving the application. I understand that the information will be used for the sole purpose of determining the applicant's eligibility for paratransit service. I agree that VIA may contact me for clarification or additional information as needed.

Medical Professional's Signature | *Date*

RETURN TO:

ACCESSIBLE SERVICES
VIA METRO CENTER
1021 SAN PEDRO AVENUE
SAN ANTONIO, TX 78212