QUESTIONS & ANSWERS

WHAT IS VIAtrans?

VIAtrans is a shared-ride, curb-to-curb transportation service for people who have a disability that prevents them from riding the bus some or all the time. Trips are available on the same days and in the same areas VIA buses operate. Trip reservations must be made one to four days in advance. Van operators help passengers on and off vehicles but do not provide medical assistance or help entering homes or other buildings. The current fare is $2.00 per one-way trip.

WHO IS ELIGIBLE?

To qualify, applicants must have a disability that prevents independent use of fixed-route bus service, at least some of the time. Individuals who are independently able to ride the bus at all times are not eligible. Eligibility is not based on age, income, residency, or inability to drive. The minimum age to use VIAtrans service is six.

HOW TO APPLY

Fill out pages 1-5 completely, and then have a medical professional who is familiar with the applicant's disability complete pages 6-8. Please mail or deliver the completed application to the address at the bottom of page 8. Do not submit copies. Do not fax. Do not email.

WHAT HAPPENS NEXT?

If information is missing, the application will not be processed. After reviewing a completed application, VIA may request additional information and/or participation in a functional assessment to assess mobility skills. Please call (210) 362-2140 if you do not receive a letter within 21 days after submitting an application and performing any additional steps requested by VIA.

Applicants who meet eligibility requirements will be approved for unconditional service (all trips), conditional service (some trips), or short-term service (3 to 12 months). VIA notifies all applicants by mail when approved or denied eligibility. Afterward, approved applicants go to the Accessible Services Department for a photo identification card and a brief orientation on how to use VIAtrans service. Applicants with a cognitive disability should be accompanied by someone who can understand the instructions. An appeals process is available for anyone disagreeing with any part of VIA's eligibility decision.

DO NOT SUBMIT COPIES. DO NOT FAX. DO NOT EMAIL.

ADDITIONAL INFORMATON

For details about VIAtrans policies, procedures, and service area, please consult the *VIAtrans Service Customer Guide* or view the video *Welcome to VIAtrans.* Both are available at 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

- Only submit original applications – **DO NOT SUBMIT COPIES. DO NOT FAX. DO NOT EMAIL.**
- Pages 6 – 8 must be completed by a doctor or other medical professional. Incomplete applications or applications with any part of the medical section completed by the applicant will not be processed.
- Please submit applications to the following address:

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

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SECTION I

Office Use Only

APPLICANT INFORMATION

PRINT

Last Name | First Name | Initial | DOB | ○ M ○ F

Home Address | Unit | City | State | ZIP

Mailing Address | Unit | City | State | ZIP

Apartment or Facility Name | 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

CHECK THE STATEMENT THAT BEST DESCRIBES THE APPLICANT'S ABILITIES

○ UNABLE TO INDEPENDENTLY RIDE THE BUS SOME OR ALL THE TIME.

○ ABLE TO INDEPENDENTLY RIDE THE BUS ALL THE TIME.

OFFICE USE ONLY

Applicant's Last Name

SECTION I

APPLICANT INFORMATION

	Can you do the following tasks?	Circle answer	Describe problems you have doing each task, or enter NA if no difficulties. 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	

DO NOT SUBMIT COPIES.

Applicant's Last Name

SECTION I

APPLICANT INFORMATION

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

APPLICATIONS WITH BLANK RESPONSES WILL NOT BE PROCESSED.

1	WHAT METHODS OF TRANSPORTATION DO YOU CURRENTLY USE?	
2	HOW MANY TIMES A MONTH DO YOU RIDE THE BUS WITHOUT ASSISTANCE?	
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.	

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Applicant's Last Name

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	

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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. After the professional completes the medical section, submit the original (no copies) to the address at the bottom of page 8.

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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* | *Date*

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	If #2 above is due to CVA, TBI, FX , GSW, or other traumatic injury, enter injury type and approximate date occurred.	
4	List assistive devices *required* for mobility.	
5	What is the applicant's height and weight?	
6	If visually impaired, what are the applicant's (corrected) visual acuities (Snellen)?	*R* *L*
7	If visually impaired, what are the applicant's field restrictions?	*R* *L*
8	If pending surgery, enter type, approximate date, and estimated recovery time.	

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HEALTH RISKS DURING FUNCTIONAL ASSESSMENT

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.** **If you check "unsafe," please elaborate why the task is unsafe.**

	TASK	SAFE	UNSAFE	IF UNSAFE, WHY? DO NOT LEAVE BLANK
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

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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

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DO NOT FAX

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