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, personal finances, or inability to drive. The minimum age to use VIAtrans service is six (6).

HOW TO APPLY?

Fill out pages 1-6 completely, and then have a medical professional who is familiar with the applicant's disability complete pages 7-10. Please mail or deliver the completed application to the address at the bottom of page 11. **Do not submit copies. Do not fax. Do not email.**

WHAT HAPPENS NEXT?

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 a complete 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 7 – 10 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.

_____
Office Use Only

SECTION I: Part A- Personal Information:

☐ **New Application**
☐ **Recertification** **VIAtrans ID #**

Name:
Last First Middle

Home Address: Apt No.:

Name of Facility or Apartment Building:

City: State: Zip Code:

Phone Number(s) List Below:

Home: Other:

Email Address:

What is your language of choice? ☐English ☐Spanish

☐Other:

Preferred communication format: ☐Standard Print ☐Large Print ☐Braille

☐Email/Electronic ☐Other:

Date of Birth: ☐Female ☐Male

Part B: Contact Persons

Emergency Contact Person:

Relationship to Applicant:

Emergency Phone Number(s) (list below):

Primary:

Other:

DO NOT SUBMIT COPIES

Part C: Tell us about your disability or disabling health condition.
What is the primary disability or condition that **prevents** you from using VIA bus service? Please be specific?
Do you have other physical or mental health disabilities or conditions that **limit** your ability to use VIA bus services? ☐YES ☐NO
If yes, please explain:
Do the effects of your disability or condition vary from day to day? ☐Yes ☐No
If yes, please explain how they vary:
Is your disability or condition: ☐Permanent ☐Temporary
How long? Month(s) Year(s)
If you answered temporary, please explain:

Part D: Condition Checklist- Not required to be completed							
☐	Amputation	☐	Breathing Condition	☐	Frail	☐	Panic
☐	Autism	☐	Cognitive Disability	☐	Memory Loss	☐	Paralysis
☐	Balance Problems	☐	Confusion	☐	Non-Verbal	☐	Psychosis
☐	Blind or Low Vision	☐	Deaf or Hard of Hearing	☐	Obesity	☐	Seizures
☐	Brain Injury	☐	Dialysis Required	☐	Pain	☐	Significant Limitation of Activity

Part E: Mobility assistance required for travel. Check all that apply. Not required to be completed.					
☐	None	☐	Prosthetic Device	☐	Portable Oxygen
☐	Cane	☐	Manual Wheelchair	☐	Respirator
☐	Walker	☐	Power Wheelchair	☐	Alphabet Board
☐	Crutches	☐	Power Scooter	☐	Other:
☐	White Cane	☐	Service Animal	☐	Other:

Part F: Tell us about your abilities to ride regular bus service. Not required to be completed					
	Can you do the following:	YES	NO	SOME TIMES	Describe problems you have doing each task, or enter **NA** if no difficulties **DO NOT LEAVE BLANK**
1	See	☐	☐	☐	
2	Hear	☐	☐	☐	
3	Talk	☐	☐	☐	

	Can you do the following:	YES	NO	SOME TIMES	Describe problems you have doing each task, or enter **NA** if no difficulties **DO NOT LEAVE BLANK**
4	Read & Write	☐	☐	☐	
5	Understand Information	☐	☐	☐	
6	Tell time	☐	☐	☐	
7	Use the telephone	☐	☐	☐	
8	Plan & Schedule Trips	☐	☐	☐	
9	Remember Information	☐	☐	☐	
10	Walk	☐	☐	☐	
11	Cross Streets	☐	☐	☐	
12	Stand & Wait	☐	☐	☐	
13	Step Up & Down a 12-inch Step	☐	☐	☐	

	Can you do the following:	YES	NO	SOME TIMES	Describe problems you have doing each task, or enter **NA** if no difficulties **DO NOT LEAVE BLANK**
14	Count & Handle Money	☐	☐	☐	
15	Interact with Others	☐	☐	☐	

Part G: Tell us about your use of regular VIA bus service.

Have you used regular VIA bus service? ☐YES ☐NO If yes, how many times a month?

If no, why have you not used regular bus service? Check all that apply:

☐	I have never tried to ride regular bus service.
☐	I have difficulty traveling to and from the bus stop.
☐	I have difficulty getting on or off the bus.
☐	I need someone to show me.
☐	I have difficulty recognizing bus stops.
☐	I cannot use the regular bus service without a personal care attendant.
☐	Other:

What other method of transportation do you use?

Part H: 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 7-10 blank for your medical professional to complete. After the professional completes the medical section, submit the original (no copies) to the address at the top of page 11.

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

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

Print Name	Signature	Relationship	Date

Address/City/State Zip Code Phone Number

APPLICANT: DO NOT MAKE ENTRIES AFTER THIS PAGE

TAKE THE APPLICATION TO YOUR MEDICAL PROFESSIONAL

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 7-10 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/regular bus system?		
3	If #2 above is due to a CVA, TBI, FX, GSW, or other traumatic injury, enter injury type and approximate date occurred.		
		Date:	
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.		

HEALTH RISK 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**
1	Ascending and descending one 12-inch step with handrails.			
2	Walking 2,640 feet on various terrains in various weather conditions.			
3	If using wheelchair or scooter, traveling without assistance on various terrain in various weather conditions.			

SECTION II: TO BE COMPLETED BY DOCTOR OR 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	EXPLANATION OF LIMITATIONS
1	**Walking** ☐No Limitations ☐Slight Limitation ☐Moderate Limitations ☐Severe Limitations ☐Do Not Know	
2	**Standing** ☐No Limitations ☐Slight Limitation ☐Moderate Limitations ☐Severe Limitations ☐Do Not Know	
3	**Stepping Up & Down** ☐No Limitations ☐Slight Limitation ☐Moderate Limitations ☐Severe Limitations ☐Do Not Know	
4	**Communicating** ☐No Limitations ☐Slight Limitation ☐Moderate Limitations ☐Severe Limitations ☐Do Not Know	
5	**Remembering** ☐No Limitations ☐Slight Limitation ☐Moderate Limitations ☐Severe Limitations ☐Do Not Know	
6	**Planning** ☐No Limitations ☐Slight Limitation ☐Moderate Limitations ☐Severe Limitations ☐Do Not Know	
7	**Interacting with Others** ☐No Limitations ☐Slight Limitation ☐Moderate Limitations ☐Severe Limitations ☐Do Not Know	

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	MONTHS TIL RECOVERY	ICD- 10 CODES	MONTHS TIL RECOVERY	ICD- 10 CODES	MONTHS TIL RECOVERY

COMMENTS:

TO BE COMPLETED BY DOCTOR/SPECIALIST

APPLICANT: DO NOT MAKE ENTRIES ON THIS PAGE

PRINT

MEDICAL PROFESSIONAL'S NAME	TITLE	LICENSE NUMBER
FACILITY/ORGANIZATION NAME	SPECIALTY #1	SPECIALTY #2
ADDRESS/UNIT NO.	CITY	STATE/ZIP
TELEPHONE	FAX	EMAIL

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

_____
Applicant's Last Name

RETURN TO:	ACCESSIBLE SERVICES VIA METRO TRANSIT 1021 SAN PEDRO AVENUE SAN ANTONIO, TX 78212	**SUBMIT ORIGINALS** **DO NO SUBMIT COPIES** **DO NOT EMAIL** **DO NOT FAX**