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 1-4 completely, and then have a medical professional who is familiar with the applicant's disability complete pages 5-7. Please mail or deliver the completed application to the address at the bottom of next page or page 7 of the application.

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.

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 5-7 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.

Applicant's Last Name: _____

APPLICATION

_____
OFFICE USE ONLY

SECTION I: PART A- PERSONAL INFORMATION
☐New Application
☐Recertification

Last Name:	First Name:	Middle Initial:
Date of Birth:	Male ☐ Female ☐	
Home Address:		Apt #:
Mailing Address:		Apt #:
Name of Facility/Apartment:		Gate Code:
City:	State:	Zip Code:
Phone Numbers:	Home:	Mobile:
Work:	Others:	
Email Address:		
Language of choice: ☐English ☐Spanish ☐Other:		
Preferred communication format: ☐ Standard Print ☐Large Print ☐Braille ☐Email/Electronic ☐ Other:		

SECTION 1: PART B- CONTACT PERSONS

Legal Guardian:	Phone Number:
Other Phone Number:	Email Address:
Emergency Contact:	Relationship to Applicant:
Emergency Contact Phone Number:	Other Phone Number:

SECTION 1: PART C- TELL US ABOUT YOUR DISABILITY OR DISABLING CONDITION

What is the primary disability or condition that **PREVENTS** you from using VIA bus service? Please be specific in describing how the disability prevents you from using VIA bus service.

Do you have other physical or mental health disabilities or conditions that **LIMIT** your ability to use VIA bus services? Yes ☐ No ☐ If yes, explain:

Do the effects of your disability or condition vary from day to day? Yes ☐ No ☐ If yes, explain:
Do the effects vary due to temperature? Hot ☐ Cold ☐ Do they vary based on time of day? Day ☐ Night ☐
Is your disability or condition: Permanent ☐ Temporary ☐ If temporary, how long? Months: Years: If temporary, explain:

SECTION 1: PART D- CONDITION CHECKLIST		
☐ Amputation	☐ Confusion	☐ Obesity
☐ Autism	☐ Deaf or Hard of Hearing	☐ Paralysis
☐ Balance Problems	☐ Dialysis Required	☐ Psychosis
☐ Blind or Low Vision	☐ Frail	☐ Seizures
☐ Brain Injury	☐ Memory Loss	☐ Weakness
☐ Breathing Condition	☐ Non-Verbal	☐ Other:
☐ Cognitive Disability	☐ Pain	☐ Other:

SECTION 1: PART E- MOBILITY EQUIPMENT OR AIDS REQUIRED TO FOR TRAVEL NOT REQUIRED		
☐ None	☐ Prosthetic Device	☐ Portable Oxygen
☐ Cane	☐ Manual Wheelchair	☐ Respirator
☐ Walker	☐ Power Wheelchair	☐ Rollator
☐ Crutches	☐ Power Scooter	☐ Alphabet Board
☐ White Cane	☐ Service Animal	☐ Other:

SECTION 1: PART F- TELL US ABOUT YOUR ABILITIES TO RIDE REGULAR BUS SERVICE				
Can you do the following?	**YES**	**NO**	**SOMETIMES**	**Describe problems you have doing each task, or enter NA if no difficulties:**
See	☐ YES	☐ NO	☐ SOMETIMES	
Hear	☐ YES	☐ NO	☐ SOMETIMES	
Talk	☐ YES	☐ NO	☐ SOMETIMES	

SECTION 1: PART F- CONTINUATION				
Can you do the following?	**YES**	**NO**	**SOMETIMES**	**Describe problems you have doing each task, or enter NA if no difficulties:**
Read & Write	☐ YES	☐ NO	☐ SOMETIMES	
Understand Information	☐ YES	☐ NO	☐ SOMETIMES	
Tell Time	☐ YES	☐ NO	☐ SOMETIMES	
Use the Telephone	☐ YES	☐ NO	☐ SOMETIMES	
Plan & Schedule Trips	☐ YES	☐ NO	☐ SOMETIMES	
Remember Information	☐ YES	☐ NO	☐ SOMETIMES	
Walk	☐ YES	☐ NO	☐ SOMETIMES	
Cross Street	☐ YES	☐ NO	☐ SOMETIMES	
Stand & Wait	☐ YES	☐ NO	☐ SOMETIMES	
Step Up & Down a 12-inch step	☐ YES	☐ NO	☐ SOMETIMES	
Count & Handle Money	☐ YES	☐ NO	☐ SOMETIMES	
Interact with Others	☐ YES	☐ NO	☐ SOMETIMES	

SECTION 1: PART G- TELL US ABOUT YOUR USE OF REGULAR VIA BUS SERVICE NOT REQUIRED	
Do you use 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 recognizing bus stops
☐ I have difficulty traveling to and from the bus stop	☐ I need someone to show me
☐ I have difficulty getting on or off the bus	☐ Nearest bus stop is too far from my home
☐ I cannot use regular bus service without a care attendant	☐ Other:
What other method of transportation do you use?	

SECTION 1: PART H- MEDICAL PROFESSIONALS NOT REQUIRED		
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:
If you are being treated by a professional not cited above, such as rehabilitation doctor or any other medical specialist, enter the name, contact information and area of specialty.		
Name:	Address:	Telephone:
Area of Specialty:		

SECTION 1: PART I- AUTHORIZATION SIGNATURE	
By signing below, the applicant certifies, or applicant's representation, certifies that all the information entered 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 infomration will remain confidential and used solely to determine eligibility. (If the applicant is under eighteen years of age, the applicant's parents, 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 5, 6, 7 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 7.	
Applicant's Signature:	Date:
Parent or Guardian Signature:	Date:

If someone else other than the applicant completed any information in Section I, please have that person sign below and enter requested information.		
Print Name:	Signature:	Date:
Address:	City:	Zip Code:
Phone Number:	Relationship to Applicant:	

APPLICANT DO NOT MAKE ENTRIES ON PAGES 5, 6 OR 7

TAKE APPLICATION TO MEDICAL PROFESSIONAL

SECTION II: PART A- MEDICAL CONDITION

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 5, 6, or 7 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.	
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.	

SECTION II: PART B- 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 explain in detail why the task is unsafe.**

	TASK	**IF UNSAFE, WHY? DO NOT LEAVE BLANK**
1	Ascending and descending one 12-inch step with handrails **SAFE** ☐ **UNSAFE** ☐	
2	Walking 2,640 feet on various terrains in various weather conditions **SAFE** ☐ **UNSAFE** ☐	
3	If using wheelchair or scooter, traveling without assistance on various terrain in various weather conditions **SAFE** ☐ **UNSAFE** ☐	

SECTION II: PART C- FUNCTIONAL ABILITIES- TO BE COMPLETED BY DOCTOR OR SPECIALIST		
FOR EACH ABILITY BELOW, INDICATE AND EXPLAIN IN DETAIL THE DEGREE OF LIMITATION RESULTING FROM THE APPLICANT'S DISABILITY.		
	ABILITIES	**EXPLANATION OF LIMITATIONS**
1	Walking ☐ No Limitations ☐ Slight Limitations ☐ Moderate Limitations ☐ Severe Limitations ☐ Do Not Know	
2	Standing ☐ No Limitations ☐ Slight Limitations ☐ Moderate Limitations ☐ Severe Limitations ☐ Do Not Know	
3	Stepping Up & Down ☐ No Limitations ☐ Slight Limitations ☐ Moderate Limitations ☐ Severe Limitations ☐ Do Not Know	
4	Communicating ☐ No Limitations ☐ Slight Limitations ☐ Moderate Limitations ☐ Severe Limitations ☐ Do Not Know	
5	Remembering ☐ No Limitations ☐ Slight Limitations ☐ Moderate Limitations ☐ Severe Limitations ☐ Do Not Know	
6	Planning ☐ No Limitations ☐ Slight Limitations ☐ Moderate Limitations ☐ Severe Limitations ☐ Do Not Know	
7	Interacting with Others ☐ No Limitations ☐ Slight Limitations ☐ Moderate Limitations ☐ Severe Limitations ☐ Do Not Know	

Applicant's Last Name: _____

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

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

ICD-10 CODE: MONTHS TIL RECOVERY:	ICD-10 CODE: MONTHS TO RECOVERY:	ICD-10 CODE: MONTHS TO RECOVERY:
ICD-10 CODE: MONTHS TIL RECOVERY:	ICD-10 CODE: MONTHS TO RECOVERY:	ICD-10 CODE: MONTHS TO RECOVERY:
ICD-10 CODE: MONTHS TIL RECOVERY:	ICD-10 CODE: MONTHS TO RECOVERY:	ICD-10 CODE: MONTHS TO RECOVERY:

TO BE COMPLETED BY DOCTOR/SPECIALIST
APPLICANT DO NOT MAKE ENTRIES ON THIS PAGE

Medical Professional Name:	License Number:
Title:	Specialty #1:
Facility/Organization Name:	Specialty #2:
Address:	

City:	State:	Zip Code:
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 SIGNATURE:

DATE:

RETURN TO:	**ACCESSIBLE SERVICES** **VIA METRO TRANSIT** **1021 SAN PEDRO AVENUE** **SAN ANTONIO, TX 78212**	**SUBMIT ORIGINALS** **DO NOT SUBMIT COPIES** **DO NOT EMAIL** **DO NOT FAX**