Trans-AID Eligibility Application
For Persons with Psychiatric Disabilities

Trans-AID, a paratransit system operating in accordance with the Americans with Disabilities Act (ADA) of 1990, is designed to serve individuals whose disabling condition or functional limitation prevents them from using regular fixed route WSTA bus services.

Who Is Eligible?

Under the ADA regulations, individuals who qualify for paratransit services (known as Trans-AID) qualify for at least one of the following three categories:

1. The individual is unable, as a result of mental, visual or physical impairment as defined in the ADA to get on, ride, or get off an accessible vehicle of the WSTA fixed route bus system;
2. The individual can use or learn to use an accessible public transportation, **BUT** such a vehicle is not available on the route when the person wants to travel;
3. The individual has a specific impairment-related condition (including limitations of vision, hearing or disorientation), which prevents travel to or from the Downtown Transportation Center or stop of the WSTA fixed route bus system.

If at least one of the above items that applies to you, identify that item by filling in the corresponding number(s) _____. (**Example - If you have a mental or physical impairment and cannot access WSTA fixed route system, you would fill in the #1).**

Eligibility: What You Should Know About This Program:

- Individuals who can access regular fixed route bus services may not be eligible for Trans-AID service.
- Trans-AID service operates where the WSTA fixed route service operates, and during the same days and hours.
- If the applicant is determined to be eligible for this program, one of three designations may be made: Unconditional, Conditional, or Temporary. Unconditional eligibility indicates that the applicant can use Trans-AID services for all trips with the service area. Conditional eligibility indicates that some trips are eligible and some not, based on functional ability to use the WSTA bus system, given the specific environment and demands of each trip. Temporary eligibility indicates that your condition is not permanent and you have an expected duration of your disability.

How to Apply

To apply for the ADA Paratransit services (Trans-AID), you must complete an ADA Paratransit Certification application, which can be obtained from the Winston-Salem Transit Authority (336.727.2000) or www.wstransit.com and clicking Paratransit. You must complete both parts of the application in its entirety in order for your application to be considered. Please complete part A of this application. Then provide both parts A & B to a medical, certified or licensed professional who is familiar with your qualifying condition.

Application Process

Once you have a completed application, please contact WSTA at 336.727.2000 to schedule an in-person interview and assessment to determine your eligibility.

On the date of your scheduled interview, please bring your completed application (both parts A & B). ***Do not mail, fax, or email your application***. Your eligibility will be based on the following factors:

- Information provided by applicant in part A of the application
- Information provided in Part B by professionals (i.e., physician or therapist) familiar with your qualifying conditions
- In-person assessment of your abilities. All in-person interviews and assessments are held at the Clark Campbell Transportation Center
    - If requested, WSTA will provide transportation at no charge to and from the appointment for eligibility determinations.

Once WSTA staff has reviewed the completed application, and conducted the in-person interview and assessment, the ADA Compliance office has 21 calendar days to determine the eligibility for the transportation services. If WSTA has not made a determination of eligibility within 21 calendar days, you will be treated as eligible and may receive Trans-AID services until WSTA makes a determination.

If you are denied Trans-AID eligibility or are granted conditional or temporary eligibility, you will receive a letter regarding the decision and a copy of the Trans-AID Appeal Process. You have the right to appeal the eligibility determination.

WSTA will continue to accept re-certification applications for passengers eligible for ADA transportation. Re-certifications are for existing passenger's eligible for Trans-AID under the ADA program. In order to continue utilizing the Trans-AID service, you are required to renew your certification every three (3) years. However, if you have been diagnosed with a permanent disability (i.e., total loss of vision, multiple sclerosis, and autism), re-certifications will take place every five (5) years; no professional verification is needed from a professional.

This application is available in alternative formats. If you would like additional assistance, please call (336) 727-2000. The information in this application will be used only to determine your eligibility for Trans-AID services, and will be kept confidential.

Trans-AID Eligibility Application
Part A

Please complete the following information:

Name: _____ Date: _____

Birth date: _____/ _____/ _____

Address: _____

City: _____ State _____ Zip _____

Please list closest intersection to home: _____

Please provide directions to your home from the Transportation Center at 100 W 5th Street

_____

_____

_____

Home telephone number: _____

Work/Other daytime telephone number: _____

If hearing impaired, TTY number: _____

If the applicant was assisted by someone else to complete this form, please list contact information below:

Name: _____ Daytime phone: _____

Address: _____

Relationship to applicant: _____

Signature: _____

Applicant's emergency contact (if different from person assisting with application):

Name: _____ Daytime phone: _____
Relationship to applicant: _____

Have you used the WSTA fixed route bus system? _____ No _____ Yes

If yes, which routes? _____

Are you currently using fixed-route transportation? _____No _____Yes

What is the closest bus stop to your home? _____

If you do not know, check N/A. _____

Can you get to the bus stop by yourself? _____ No _____ Yes

If no, what limits you from getting there? _____

If you do not know, check N/A._____
Language Ability (Please check all that apply _____English _____Spanish
_____Other (specify) _____

Please describe the disability or health condition that prevents you from using fixed route buses. (Please list all disabilities and/ or health conditions that apply)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you ever had a seizure?

☐ Yes

☐ No

If yes, what type? _____

Are you taking medication to control the seizure?

☐ Yes

☐ No

What is the expected duration of this individual's condition?

☐ Temporary: Approximate expected duration until _____/_____/_____

☐ Long-term: Potential for improvement or periods of remission

☐ Permanent: No expectation of functional improvement

Which of the following mobility aids do you use? (Please check all that apply)

____Cane	____Manual wheelchair	____Service animal
____White cane	____Powered wheelchair	____Picture board
____Walker	____Powered scooter/cart	____Alphabet board
____Crutches	____Boarding chair	____Portable oxygen
____Prosthesis	____Transfer board	____**None of these**

____Other (describe):_____

Please check any of the following environmental or individual factors which are applicable to your situation:

1. Environment:
If I use the Regular (Fixed Route), I must have:
_____ a bench _____ a shelter _____ nothing additional

When crossing a street, I need:
____curb cuts ____ tactile curb warnings ____audible signals
____accessible median strip ____no more than (#___) lanes of traffic

I cannot make my way across ground which is:
____ paved or sidewalk ____ grassy ____ gravel ____ hilly

My ability to access transportation is affected by weather which is:
____ warm (above ____ degrees) ____cold (below ____ degrees)
____ rainy ____icy ____windy

My ability to access transportation is dependent on the time of day. I cannot see in:
____ full daylight ____partial daylight ____darkness /semi-darkness

My ability to access stairs is as follows. I can manage:
____ only one or two steps ____only with a handrail ____ no steps

2. Individual

How far can you walk **by yourself** or with the assistance of a mobility aid?

____ I can get from the curb in front of the house/ apartment
____ I can travel up to 3 blocks (1/4 mile)
____ I can travel up to 6 blocks (1/2 mile)
____ I can travel up to 9 blocks (3/4 mile)
____ I can't travel outside my house/ apartment

Are you able to get to and from the bus stop **by yourself**?

____ Yes ____ No

If No, check reasons that apply:

____ I cannot travel outside of my house or apartment
____ I can only get to the curb in front of my house or apartment
____ I can if someone is with me to assist me
____ I cannot get to places where there are no curb cuts
____ I cannot cross busy streets or intersections
____ I cannot travel outside when it is too hot
____ I cannot find my way at night due to a vision problem

I can wait at a bus stop

No more than (#____) minutes ____ at least one hour

The bus stop which I can access

____ must be stops for which I have received formal travel training
____ must be only areas in familiar to me

I travel: ____alone ____both alone and with a companion

____ only with an attendant or companion (this does NOT affect eligibility)

If you travel with someone who assists you, does this person assist you in:

____ Getting to or from bus stops
____ Getting on or off the bus
____ To help me where I am going
____ Other (describe): _____

I can cross a street with ____2-3 lanes ____4-6 lanes ____ I cannot cross

List your 5-6 most frequent destinations and how you currently get there:

Destination	Frequency of travel	How you get there now:

List places you would like to go but cannot currently access:

Destination	Frequency desired	Barriers to your access

If you use a manual or powered wheelchair or scooter, what year, make and model is it?

If you use a manual or powered wheelchair or scooter, is it more than 30-inches wide, more than 48-inches long, or does it weigh more than 600 pounds (person plus mobility device)? ____ Yes ____ No

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I have received and read the Trans-AID Eligibility Application for persons with disabilities. I have read and understand who is eligible, how to apply for Trans-AID, and the process of qualifying for services after I turn in the completed application. I understand that it is my responsibility, or an appointed representative, to read the guidelines and requirements of the Trans-AID eligibility process.

I understand the purpose of the application is to determine if I am eligible for the Trans-AID service. I certify the information I gave in the application is true and correct, and the application will be returned to me if not completed in its entirety; which delays the process. I recognize that falsification or misrepresentation of facts or changes in my medical condition may result in changes to my certification status. I further realize that additional information from my healthcare professional related to the disability or medical condition is required; and may be used to help determine my eligibility.

I understand that Part A must be completed in order for the application to be considered eligible. It is further acknowledged that the determination of my eligibility is based on the completed application.

Applicant Signature Date

(***Applicants must be 18 years of age to sign independently. Otherwise, the signature of a parent or guardian is required***)

Part B of this application must be filled out by a health care or human services professional who is familiar with the applicant's disabling condition and/or functional limitation.

Your signature on the application authorizes this professional to provide information to the Trans-AID regarding your eligibility for ADA services and any needed clarification of functional limitations due to your disabling condition.

In the space provided below, CLEARLY PRINT the name of the professional who will be verifying your application, and specify his/her position.

Name of professional: _____

Professional affiliation (check the appropriate designation):

- ☐ Licensed physician
- ☐ Licensed physical therapist
- ☐ Licensed occupational therapist
- ☐ Licensed social worker
- ☐ Nurse (LPN or RN)
- ☐ Certified psychologist
- ☐ Certified rehabilitation counselor
- ☐ Speech pathologist
- ☐ Vision specialist
- ☐ Orientation/Mobility specialist
- ☐ Audiologist/Hearing specialist
- ☐ MR/DD qualified specialist

Release of Information

Because I receive services from the following rehabilitation facility or health care professional or agency which is familiar with my disability, you have my permission to discuss or provide healthcare information to the ADA Coordinator of the Winston-Salem Transit Authority, should they need to contact you for the purpose of completing this certification procedure.

(Please use a separate form for each agency)

Name: _____

Address:

_____

_____

Staff person familiar with the case: _____

I understand that this information will be held by WSTA in the strictest confidence and will not be shared with any other person or agency, unless it is needed for an Appeal Hearing with the Trans-Aid Appeal Committee.

Signature of Applicant: _____

Witness: _____

Date: _____

Trans-AID Eligibility Application – Part B
Professional ADA Verification

You are being asked by the applicant named in Part A of this application to provide information regarding his/her ability to use the public transportation services of the Winston-Salem Transit Authority. WSTA provides ADA paratransit services through Trans-AID to ADA eligible persons with disabilities who cannot use regular services. The information you provide will allow us to evaluate the request and determine the individual's specific needs. Thank you for your cooperation in this matter.

PLEASE NOTE: WSTA fixed route transit services available within the city are currently accessible to persons with disabilities who need lift-equipped vehicles, vehicles which kneel to the curb, and/or announcement of bus stops. The individual applying for Trans-AID service **MUST BE UNABLE TO ACCESS THESE SERVICES** due to:

- ~ Conditions which prevent them from getting to or from a WSTA fixed bus stop, or transferring between vehicles **and/or**
- ~ Conditions which prevent them from being able to independently get on, ride, or get off a lift-equipped vehicle.

Individuals for whom performing these tasks is inconvenient or uncomfortable are **NOT ELIGIBLE** for services, and you are asked to verify this information.

Eligibility for Trans-AID is determined on a trip by trip basis. It is **extremely important** that you provide specific information about the individual's **functional** limitations, so these determinations can be made. For example, an individual who can easily and safely get to the bus stop nearest their home may not be able to get to a bus stop at their desired destination and thus would be eligible for transportation based on the destination.

Please follow these steps to verify this application:

1. Read Part A of the application in its entirety.
2. Fill out Part B of the application completely, using the criteria provided.
3. Return the completed application to the applicant within 7 days of receipt. The applicant is responsible for returning the application to WSTA.
4. Be aware that you may be contacted for further information if questions remain about the applicant's abilities.
5. If you have any questions, contact WSTA at (336) 727-2000. If you use a TTY, call 1-800-735-8262 and ask to be connected to (336) 727-2000

Part B – Professional Verification, continued

Name of Client: _____

I have read Part A in its entirety: _____ Yes _____ No

I agree with the information provided in Part A: _____ Yes _____ No

1. In what capacity do you know the applicant?

_____
_____

2. How long have you known or worked with the applicant?

_____

3. When did you last see or treat the applicant?

_____
_____

Please state more detailed information about the stated disability and the extent of the disability.

4. What is the formal diagnosis of the applicant's disability (DSM-IV or other)?

_____
_____

5. What was the date of onset?

_____

6. What is the prognosis?

_____

7. Is the applicant taking any psychotropic, antidepressant or other medication(s) prescribed by you?

__ Yes __ No

Comments:

_____
_____

8. If **YES**, please list the type, frequency, dose, and any comments about how the medication(s) may complicate the individual's independent mobility in the community.

Medication	Dosage/ Frequency	Affect on Functional Ability (if any)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Part B – Professional Verification, continued

9. Does the applicant takes his/her medication compliantly; will he/she be able to travel independently in the community?
__ Yes __ No
Comments:
_____
_____

10. Do you deem the applicant to be compliant in taking prescribed medication?
__ Yes __ No

11. Is there anything about the use of medication that would complicate the applicant's use of public transportation?
__ Yes __ No
If **YES**, please explain.
_____
_____

12. Has the applicant's functional ability decreased temporarily due to adjustment to medication?
__ Yes __ No

13. If **YES**, please explain, and note the expected duration of the decrease in functional ability.
_____
_____

14. Does the applicant currently experience either auditory or visual hallucinations?
__ Yes __ No

15. If **YES**, would he/she be likely to experience auditory or visual misperceptions due to hallucinations?
__ Yes __ No
Comments:
_____
_____

16. Are any of the following skills affected by the applicant's disability? If YES, please explain, describing the effect and the extent of limitation caused by the disability. Is the applicant able to:

Travel alone outside the house
__Yes __No __Sometimes

Leave the house on time
__Yes __No __Sometimes

Part B – Professional Verification, continued

Seek and act on directions
__Yes __No __Sometimes

Find way to/from bus stop
__Yes __No __Sometimes

Cross streets
__Yes __No __Sometimes

Wait for a bus
__Yes __No __Sometimes

Board the correct bus
__Yes __No __Sometimes

Ride on the bus
__Yes __No __Sometimes

Exit at the correct destination
__Yes __No __Sometimes

Transfer to a second bus
__Yes __No __Sometimes

Monitor time
__Yes __No __Sometimes

Deal with unexpected situations
__Yes __No __Sometimes

Comments:
_____
_____
_____
_____
_____
_____

Part B – Professional Verification, continued

17. Are any of the following affected by his/her disability? If YES, please explain.

Judgment
__Yes __No __Sometimes

Problem solving
__Yes __No __Sometimes

Insight (recognizing a problem)
__Yes __No __Sometimes

Coping skills
__Yes __No __Sometimes

Short-term memory
__Yes __No __Sometimes

Long-term memory
__Yes __No __Sometimes

Concentration
__Yes __No __Sometimes

Orientation
__Yes __No __Sometimes

Communication
__Yes __No __Sometimes

Attention to task (distractibility)
__Yes __No __Sometimes

Comments:
_____
_____
_____
_____
_____
_____

Part B – Professional Verification, continued

18. Would training, driver assistance, or tools such as ID cards, printed route directions, etc., help to minimize the effects noted above?
__ Yes __ No
Comments:
_____
_____

19. Is the goal of traveling independently (even limited travel in the neighborhood) within the context of treatment?
__ Yes __ No
Comments:
_____
_____

20. Would the use of alternative transportation (ADA paratransit service) conflict with the goals of therapy, such as confidence building?
__ Yes __ No
Comments:
_____
_____

21. Would alternative transportation interfere with the applicant's therapy or improvement?
__ Yes __ No
Comments:
_____
_____

22. Does the applicant demonstrate inappropriate social behavior (for example, is he/she aggressive or overly friendly)? If YES, please describe.
__ Yes __ No
Comments:
_____
_____

23. Comments regarding current travel and activities:
_____
_____

24. Does the individual drive a car?
__ Yes __ No
Comments:
_____

Part B – Professional Verification, continued

25. Are there any other life skills that the individual lacks that would be an indication of his/her inability to travel on a fixed route bus? If YES, please describe.
__ Yes __ No
Comments:
_____
_____

26. Is there any additional information regarding this individual that you believe affects his/her functional ability to use regular fixed route bus service, or any special circumstances that you believe should be considered?
_____
_____
_____

What is the expected duration of this individual's condition?

☐ Temporary: Approximate expected duration until _____/_____/_____

☐ Long-term: Potential for improvement or periods of remission

☐ Permanent: No expectation of functional improvement

Please choose the statement below which best represents your opinion regarding this individual's use of fixed route bus services:

☐ This individual should be able to access fixed route bus services successfully

☐ This individual can use fixed route bus services under certain situations as stated above

☐ This individual cannot use fixed route bus services due to multiple functional limitations

Thank you for your assistance!!

Date: _____

Signature: _____

Printed Name: _____

Address: _____

Phone # _____

Organization / Practice: _____