Trans-AID Eligibility Application
For Persons with Seizure Disorders

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 your application is completed, contact WSTA’s ADA Department at 336.727.2000 to request a site assessment of your/the client’s residence. Our Safety Department will come to the residence or point of origin to access the exterior to ensure our vans can provide transportation to the location safely. Once we have received the completed environmental evaluation from the Safety Department, a representative from WSTA’s ADA Department will call to schedule an in-person interview and functional 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: _________________________________________________ |

Trans-AID Services

Revised: January 2023
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

Trans-AID Services

Revised: January 2023
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

Trans-AID Services 5

Revised: January 2023
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 in areas 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:

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<tr>
<th>Destination</th>
<th>Frequency of travel</th>
<th>How you get there now:</th>
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List places you would like to go but cannot currently access:

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<th>Destination</th>
<th>Frequency desired</th>
<th>Barriers to your access</th>
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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?
________________________________________________________________________
________________________________________________________________________

4. Please describe what the applicant experiences during and after a seizure.
________________________________________________________________________
________________________________________________________________________

5. How often do seizures occur?
________________________________________________________________________
________________________________________________________________________

6. What is the prognosis?
________________________________________________________________________
________________________________________________________________________

7. Are the seizures preceded by an aura?
__ Yes __ No __ Sometimes

8. If YES or SOMETIMES, does the applicant usually have time to prepare and make
him or herself as safe as possible?
________________________________________________________________________
________________________________________________________________________

9. Are there certain things that will trigger the applicant's seizures?
__ Yes __ No

10. If YES, please describe these triggers.
________________________________________________________________________
________________________________________________________________________
Part B – Professional Verification, continued

11. Please describe the applicant's ability to travel alone in the community. When and where can he/she safely travel?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

12. What advice or limitations on traveling alone in the community have been communicated to the applicant?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

13. Is the applicant permitted to drive?
   __ Yes   __ No
   Comments:

14. Is the applicant taking any medication(s) prescribed by you or another professional?
   __ Yes   __ No
   Comments:

15. 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.

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<th>Medication</th>
<th>Dosage/ Frequency</th>
<th>Affect on Functional Ability (if any)</th>
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15. If the applicant takes his/her medication compliantly, will he/she be able to travel independently in the community?
   __ Yes   __ No

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

18. Is there anything about the use of medication that would complicate the individual's use of public transportation?
   __ Yes   __ No
   If YES, please explain.
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Part B – Professional Verification, continued

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

20. If YES, please explain, and note the expected duration of the decrease in functional ability.
    ______________________________________________________________________
    ______________________________________________________________________
    ______________________________________________________________________

Verify information about places to which the applicant now travels and his/her typical activities.

21. Comments about the applicant's typical activities and current travel destinations.
    ______________________________________________________________________
    ______________________________________________________________________
    ______________________________________________________________________

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: ________________________________________________