Trans-AID Eligibility Application
For Person's 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, even with training;
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) _________. (**ex. If you have a mental or physical impairment and cannot access WSTA fixed route system, then you would fill in the #1).**

Eligibility: What You Should Know About This Program:

- Individuals who can access regular fixed route bus services are not eligible for Trans-AID service.
- Trans-ID 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 two 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

1. Complete an ADA Paratransit Certification form attained from the ADA Coordinator.
2. If you believe you qualify for Trans-AID, complete part A of this application.
3. Provide the application – both parts A & B – to an authorizing professional. Both parts of the application must be completed in order for your application to be considered.
4. Mail the completed applications (both parts A&B) to:

    Winston-Salem Transit Authority
    Mobility Management Department
    100 West Fifth Street
    Winston-Salem, NC 27101

    Or fax the completed application to (336) 748-3161

What Happens After I Turn in My Application

1. After WSTA has received your application, you will be contacted within 21 business days by the WSTA ADA Coordinator/staff to schedule an in-person interview and functional assessment to determine your eligibility based on the following factors:
    a. Information provided on your application.
    b. Information provided by your authorizing professional.
    c. Results of a brief assessment of your actual functional abilities.
    d. A review of available transportation options in the areas in which you desire to travel.
    - All in-person interviews and functional assessments are held at the Clark Campbell Transportation Center.
    - If needed, the WSTA ADA Coordinator will schedule an interview and functional assessment in your work setting.
2. If you have questions or have not been contacted within 21 business days of submitting your application, call the ADA Coordinator at (336) 727-2000. If you use a TTY, call 1-800-735-8262. If, at that time a determination of your eligibility has not been made, you will be temporarily eligible for Trans-AID service until such time as your application can be reviewed.
3. If you are denied Trans-AID eligibility, you will receive a letter regarding this decision and a copy of the Trans-AID Appeals Process. You have the right to appeal. For more information, contact the WSTA/ ADA Coordinator at (336) 727-2000. If you use a TTY, call 1-800-735-8262.

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: ____

Birth date: _______/ _______/ _______

Address: ____

City: ______________________________ State ______________ Zip __________

Home telephone number: ____

Work/Other daytime telephone number: _____________________________________

If hearing impaired, TTY number: ____

I certify that the information contained in this application is correct and authorize the above-named professional to provide verification of my condition and supporting information as needed:

Applicant's signature: ____

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: _____________

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
____White cane
____Walker
____Crutches
____Prosthesis
____Other (describe):
____Manual wheelchair
____Powered wheelchair
____Powered scooter/cart
____Boarding chair
____Transfer board
____Service animal
____Picture board
____Alphabet board
____Portable oxygen
____None of these

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

Using a mobility aid or on your own, how far can you travel?
____ 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

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 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

Part B of this application must be filled out by a health care or human services professional who is familiar with the applicants 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

<u>Personal Care Attendant(s):</u>
If you require mobility assistance from one or more Personal Care Attendants, please complete the following information:

Personal Care Attendant Name: ______________________________________

Telephone number: ____

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 Board.

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 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

Part B – Professional Verification, continued

__Yes __No __Sometimes

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 public transportation:

- ☐ This individual should be able to access public transportation successfully.
- ☐ This individual can use public transportation under certain situations as stated above.
- ☐ This individual cannot use public transportation due to multiple functional limitations

Thank you for your assistance!!

Date: ____

Signature: ____

Printed Name: ____

Address: ____

Phone # ____

Organization / Practice: ____

Winston Salem Transit Authority
Trans-AID Paratransit Services
Trans-AID Application Agreement

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 that both Part A and Part B must be completed in order for the application to be considered eligible, and that Part B of the application has to be completed by an authorizing professional.

I also understand that I will be contacted within 21 business days after the receipt of the completed application by the WSTA ADA Coordinator, who will schedule an in-person interview and functional assessment at the Clark Campbell Transportation Center at 100 West 5th Street in Winston-Salem, NC.

It is further acknowledged that the determination of my eligibility is based on the completed application, information provided by the authorizing professional, the assessment of my functional capabilities, and the review of available transportation options in the areas in which I desire to travel.

______________________________ ____________________

(Applicant's Signature) (Date)