

## Winchester Para-Transit Eligibility Application (CURB-TO-CURB PARA-TRANSIT SERVICE)

In compliance with the *Americans with Disabilities Act of 1990* (ADA), City of Winchester Transit System provides a curb-to-curb, shared-ride, Para-transit service. This program is available to persons with whose functional limitations make it impossible to use Winchester's regular transit service (fixed route). To be eligible for service, the functional limitations of an individual's disability must **prevent** use of regular fixed route buses or vans. **Para-transit service is not available to persons who find it uncomfortable or difficult to get to and from bus stops.**

**THE APPLICATION MUST BE CERTIFIED BY A LICENSED OR CERTIFIED HEALTH CARE PROFESSIONAL.**

This service is available within the city limits of Winchester through Winchester Transit. This is a curb-to-curb service available on a reservation only basis.

Each application will be evaluated on a case-by-case basis, taking into consideration all of the information provided.

Applications are processed in the order in which they are received. Within 21 days of receipt of a completed application, an eligibility determination will be made. You will be notified in writing as to the determination.

- If your application is denied, you will be notified of the reason and given information on our appeal process.

**It is very important that the application is filled out *completely*. Applications that are incomplete or illegible will be returned. We can only process applications with original signatures. We cannot accept faxed or photocopied applications.**

Additional applications are available online at [www.winchesterva.gov](http://www.winchesterva.gov) or by calling Winchester Transit at 540-662-3982.

If you have any questions concerning the application or the service, please contact the Winchester Transit office at (540)662-3982.

Mail completed applications to: Winchester Transit  
301 E. Cork Street  
Winchester, VA 22601

**Note: If you are 80 years or older, you automatically qualify for curb-to-curb service. Complete PAGE 1 ONLY of the application and attach a copy of proof of your age (birth certificate, baptismal certificate, etc.)  
PROOF OF AGE AND PHOTO MUST BE ATTACHED.**

For Office Use Only	
ID # _____	Exp. Date _____
Date Issued: _____	
Approved by: _____	Date: _____
Denied by: _____	Date: _____

**Para-Transit Application**

**PART I. GENERAL INFORMATION**

Name: _____		Female _____	Male _____
_____	_____	_____	_____
Last	First	Middle Initial	
Street Address _____		Apt. or Bldg. # _____	
City _____	State _____	Zip _____	
County of Residence _____		E-mail Address (optional) _____	
Mailing Address if different from above _____			
Home Phone: _____		Work Phone: _____	
Social Security Number: <b>000-00-_____</b> (Last 4 digits only)		Date of Birth: _____	
<b>Emergency Contact:</b>			
Name: _____		Relationship: _____	
Home Phone: _____		Work Phone: _____	

**PART II. USING OUR REGULAR SERVICE (FIXED ROUTE)**

**Please indicate below if you use any of the following mobility aids or equipment.**

- walking cane
- manual wheelchair
- orthopedic cane (3-4 prong)
- powered wheelchair
- long white cane (for the vision impaired)
- powered scooter/cart
- service/guide animal (describe) \_\_\_\_\_
- respirator/oxygen tank
- walker
- other
- leg braces
- I don't require any assistive devices.

**Have you ever used our regular transit service (fixed route bus or van)?**

- Yes, I typically ride \_\_\_\_\_ times a week.
- Yes, I used to but stopped because \_\_\_\_\_
- No
- No, but I would be interested in learning how to use your regular service.

Other: \_\_\_\_\_

**How far from your home is the nearest bus stop?**

- Less than 1 block
- 5 or more blocks
- 1-2 blocks
- I don't know
- 3-4 blocks

**On your own, or using your assistive device, how far can you travel on level ground?**

- I can get to the curb in front of my 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)

**WITHOUT the help of someone else can you....**

- a. Ask for, understand, and follow written or spoken instructions?  
( ) yes                      ( ) no                      ( ) sometimes \_\_\_\_\_
- b. Cross the street, either on your own or with an assistive device?  
( ) yes                      ( ) no                      ( ) sometimes \_\_\_\_\_
- c. Stand for 30 minutes if there is no place to sit?  
( ) yes                      ( ) no                      ( ) sometimes \_\_\_\_\_
- d. Step on and off a sidewalk from the curb?  
( ) yes                      ( ) no                      ( ) sometimes \_\_\_\_\_
- e. Find your own way to the bus stop if someone shows you the way once?  
( ) yes                      ( ) no                      ( ) sometimes \_\_\_\_\_
- f. Walk up and down three steps if there is a handrail?  
( ) yes                      ( ) no                      ( ) sometimes \_\_\_\_\_
- g. Walk up and down a flight of stairs if there is a handrail?  
( ) yes                      ( ) no                      ( ) sometimes \_\_\_\_\_
- h. Stand on a moving bus holding onto a handrail?  
( ) yes                      ( ) no                      ( ) sometimes \_\_\_\_\_

**Please explain how your disability prevents you from using our regular transit service (fixed route). Be specific.**

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**PART III. APPLICANT CERTIFICATION**

I certify to the best of my knowledge and ability, the information in this application is true and correct.

I hereby authorize permission to the licensed health care professional to release any relevant information for the purpose of evaluating my eligibility to use Para-transit service.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this application was completed for you by another person, please provide the following information.

Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Agency or Clinic (if applicable) \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Applicant: \_\_\_\_\_

#### PART IV: PROFESSIONAL CERTIFICATION

This portion of the form must be completed by a licensed health care professional.

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The *Americans with Disabilities Act of 1990 (ADA)* requires the provision of Para-transit (i.e. curb-to-curb) service to **anyone who is prevented from using the regular transit system, by reason of physical or mental limitation, and who is traveling in an area served by the system.** The applicant who has asked you to review and sign this form is seeking eligibility for Para-transit Specialized Transportation service. This application form is intended to determine whether the applicant can use regular transit service (fixed route) or whether he/she requires curb-to-curb service.

**Resources for this program are limited. Please exercise care in evaluating applicants. Your evaluation must be based solely upon the applicant's ability to use regular transit. False verification could result in travel limitations for persons legitimately qualified to use this program.**

**Please carefully review the information provided by the applicant and then answer the questions below.**

#### INFORMATION ABOUT THE APPLICANT'S DISABILITY

**Please mark all the disabilities which prevent the applicant from using the bus service. Conditions which make it difficult or uncomfortable should not be checked.**

##### Neuromuscular

- Amputation of (specify) \_\_\_\_\_
- Cerebral Palsy
- Muscular Dystrophy
- Parkinson's disease
- Spinal Bifida
- Stroke/Brain Injury
- Quadriplegia
- Multiple Sclerosis
- Paraplegia
- Polio
- Arthritis
- Other: \_\_\_\_\_

##### Cardiovascular

- Arteriosclerosis
- Asthma
- Cystic Fibrosis
- Heart Attack
- Emphysema
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Peripheral Vascular Disease
- Thrombosis (Chronic)
- Other: \_\_\_\_\_

##### Cognitive/Psychological

- Alzheimer's disease
- Autism
- Dementia
- Head Trauma
- Mental Retardation
- Panic Disorder
- Schizophrenia
- Other: \_\_\_\_\_

##### General Medical

- AIDS
- Diabetes (severe)
- Cancer
- Lupus
- Epilepsy (severe)
- Kidney Disease/Dialysis
- Other: \_\_\_\_\_

**VISION** (Mark All That Apply)

	<b>One Eye</b>	<b>Both Eyes</b>
Cataracts	( )	( )
Glaucoma	( )	( )
Macular Degeneration	( )	( )
Retinal Detachment	( )	( )
Retinopathy	( )	( )
Totally Blind	( )	( )
Legally Blind	( )	( )
Other _____	( )	( )

What disability **prevents** the applicant from riding the regular bus system? A detailed diagnosis is required. Please be specific. (Please do not use diagnostic codes).

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How does this disability affect the applicant's functional ability and prevent him/her from riding the regular bus system? (Please explain in detail).

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Is this condition: Permanent ( ) Temporary ( )

If temporary, what is the expected duration? \_\_\_\_\_  
(Number of months)

Does the applicant's disability require that he or she travel with an attendant?

( ) Yes            ( ) No            ( ) Sometimes

If yes or sometimes, please explain:

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Is the applicant able to travel to and from a bus stop?

( ) Yes ( ) No

If no, please indicate all that apply.

- ( ) Cannot negotiate if the street or sidewalk is too steep.
- ( ) Cannot travel if there are no curb cuts.
- ( ) Cannot cross busy streets and intersections.
- ( ) Cannot tolerate extreme temperatures.
- ( ) Cannot locate bus stops due to a visual impairment.
- ( ) Cannot walk outside without support for 15 minutes.
- ( ) Easily becomes confused and may get lost.
- ( ) Other (please specify) \_\_\_\_\_

Indicate the individual's ability to independently perform the following functions using the most effective mobility aid.

	<u>Little or no Difficulty</u>	<u>Discomfort and/or some inconvenience/ Difficulty</u>	<u>Severe pain or difficulty and additional Impairment</u>	<u>Impossible or likely to cause a serious medical crisis</u>
Find his or her way Between familiar Locations	_____	_____	_____	_____
Handle money or tickets	_____	_____	_____	_____
Recognize a destination Or landmark	_____	_____	_____	_____
Ask for, understand and Follow directions	_____	_____	_____	_____
Travel 200 feet (city block)	_____	_____	_____	_____
Travel ¼ mile (3 blocks)	_____	_____	_____	_____
Deal with unexpected Situations or unexpected Changes in routine	_____	_____	_____	_____
Safely and effectively Travel through crowded and/or complex facilities	_____	_____	_____	_____

Is the applicant able to board and disembark from a bus or van equipped with a wheelchair lift?

( ) Yes ( ) No

If no, please explain:

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**Applications with illegible or incomplete information will be returned.  
Please use medical office stamp if available.**

Person completing certification: \_\_\_\_\_

Professional Title: \_\_\_\_\_

Business Address: \_\_\_\_\_

Clinic or Agency: \_\_\_\_\_

Business Telephone: \_\_\_\_\_

I verify that the information provided for certification is true and correct.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date