



GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES

o
DEPARTMENT OF PUBLIC WORKS
6002 Estate Anna's Hope
Christiansted, St. Croix, U.S.V.I. 00820-4428

Office of Public Transportation

Telephone: (340) 773-1290 Ext. 2231

Fax: (340) 778-8906

VITRAN Paratransit Plus ADA Service Application

There are two types of public transportation available throughout the U.S. Virgin Islands:

Fixed Route Service (regular city buses) provides service at designated bus stops along specific routes on set schedules. All buses now have features to make riding easier for people with disabilities, including wheelchair lifts, kneeling features, low floor buses, and voice announcements.

ADA Paratransit Service (door-to-door) shared-ride public transportation service for people whose disability prevents them from using Fixed Route Service (regular city buses). You must call in advance to make a reservation to travel.

If your disability or environmental barriers, prevent you from using Fixed Route service (regular city buses), you may be eligible for Paratransit Service (door-to-door) some or all of the time. Your ability to ride Fixed Route buses (regular city buses) will be evaluated through the use of this application, an in-person interview and a functional assessment. A determination will be made within 21 calendar days of your in-person interview or presumptive eligibility will be granted.

*Please be sure to contact the Division of Transportation at the Department of Public Works to schedule an in-person interview at 773-1290, Ext. 2231. It is to your benefit to schedule as soon as possible. Your application will not be processed without this step.

If you need any auxiliary aide or translation during your in-person interview, please give three to five business days advance notice.

What is the American with Disabilities Act (ADA)?

The Americans with Disabilities Act (ADA) is a civil rights law. The intent of the ADA is to remove barriers that have prevented people with disabilities from fully participating in life. Under the ADA, Fixed Route service (regular city buses) is to be the primary means of public transportation for everyone, including people with disabilities.

Questions to applicant regarding disability: Applicant: _____

1. Describe your disability and how you believe it prevents or limits your use of the regular city bus. **Please be specific:** _____

2. Is the condition(s) Permanent? Yes No Temporary? Yes No
If temporary, what is the expected duration? _____

3. How do you travel now? Walk Drive a Car Ride in a Car Taxi
 Fixed Route Paratransit Fixed Route & Paratransit
 Other _____

4. Which of these aids do you currently use when traveling?

<input type="checkbox"/> None	<input type="checkbox"/> Straight Cane	<input type="checkbox"/> Ride in a Car
<input type="checkbox"/> Walker	<input type="checkbox"/> White Cane	<input type="checkbox"/> Ride in a Car
<input type="checkbox"/> Service Animal	<input type="checkbox"/> Crutches	<input type="checkbox"/> Ride in a Car
<input type="checkbox"/> Prosthetic Leg	<input type="checkbox"/> Manual Wheelchair	<input type="checkbox"/> Ride in a Car
<input type="checkbox"/> Power Scooter	<input type="checkbox"/> Rollator	<input type="checkbox"/> Alphabet/Picture Board
<input type="checkbox"/> Segway	<input type="checkbox"/> Leg Brace	<input type="checkbox"/> Power/Electric Wheelchair
<input type="checkbox"/> Portable Oxygen	<input type="checkbox"/> Other (<i>Be Specific</i>) _____	

If you use a wheelchair or scooter, is it considered extra wide? Yes No

5. Do you need assistance (Personal Care Assistant – PCA) when you travel in the community? Yes No Sometimes

6. Can you climb three steps (1 to 15 inches) with a handrail, without assistance from another person? Yes No Sometimes

7. Have you ever used the regular city bus? Yes No
If yes, why are you no longer able to use it? _____

8. Does weather impact your ability to use the regular city bus?
 Yes No Sometimes
How? _____

9. Describe the terrain around your home or apartment in relation to getting to the bus stop (sidewalks, Hills, grass, gravel, distance, etc.). _____

10. Are you able to get to the closest bus stop from your home?
 Yes No Sometimes
If no or sometimes, what prevents you? _____

11. Can you cross at streets with very little traffic, where there are not traffic controls or stop signs without assistance?
 Yes No Sometimes
If no or sometimes, what prevents you? _____

12. Can you cross at traffic lights? Yes No Sometimes
If no or sometimes, what prevents you? _____

13. Can you cross at busy intersections? Yes No Sometimes
If no or sometimes, what prevents you? _____

14. Are you able to ask for and follow written or oral information?
 Yes No Sometimes
If no or sometimes, what prevents you? _____

15. Are you able to recognize your destination or landmark near your destination?
 Yes No Sometimes
If no or sometimes, what prevents you? _____

16. Are you able to tell time? Yes No

17. Are you able to count money? Yes No

Is there any other information you want to provide that will help us in making an appropriate eligibility determination? _____

Application must be signed to be considered complete.

Applicant's Signature

I understand that the purpose of this application form is to determine if there are times when I cannot use VITRAN Fixed Route buses and will require paratransit services. I understand that the information on this application will be kept confidential and shared only with the professionals involved in evaluating my eligibility. I certify that to the best of my knowledge, the information on this application is true and correct. I understand that providing false or misleading information could result in my eligibility status being terminated.

I give permission for VITRAN Paratransit Plus staff to contact the professional who has filled out this application or given supplemental verification of my condition.

Print Name (Applicant)

Applicant's Signature

Date _____

Person completing this form if other than Applicant (check one):

- I certify that the information in this application is true and correct based upon the information given to me by the applicant.
- I certify that the information provided in this application is true and correct based upon my own knowledge of the applicant's health condition or disability or I have legal authority to complete this application.

Print Name _____

Signature _____

Day Phone _____

Date _____

Address _____ Island _____ Zip _____

Relationship to Applicant : _____

Agency Name _____

Applicant: _____

Dear Health Care Professional:

In order to complete this application on behalf of the applicant, you must be either a certified or license professional.

Your client or patient is applying for VITRAN's Americans with Disabilities Act (ADA) Paratransit Plus service. To be eligible for this service, an individual must be unable, due to a mental or physical disability, to independently use accessible fixed route buses. Please note that all fixed route buses are equipped with ramps or lifts, thus eliminating the need to negotiate stairs. Driver assistance on and off the Paratransit bus is provided, if needed. Your participation is vital, as incomplete applications will not be considered and your client will not be able to use the ADA Paratransit service. Please keep in mind, the more complete information you provide regarding your client's abilities and travel challenges, the better VITRAN Paratransit staff can determine which travel service is appropriate for your client.

If you have any questions while completing Part B, please contact us at 340-773-1290, Ext. 2231.

Please note: If you do not have Part A, you will need to return Part B to the applicant. We must receive both part A and Part B as one submission.

Who can complete Part B: (must be licensed/certified)

- | | |
|--|--|
| <input type="checkbox"/> Rehabilitation Specialist | <input type="checkbox"/> Orientation & Mobility Instructor (O&M) |
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Respiratory Therapist | <input type="checkbox"/> Physician Assistant (PA) |
| <input type="checkbox"/> Oncologist | <input type="checkbox"/> Podiatrist |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Nurse (Practitioner/RN/LPN) |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Optometrist/Ophthalmologist |
| <input type="checkbox"/> Independent Living Specialist | <input type="checkbox"/> Speech Pathologist |

Applicant: _____

PART B – To be completed by a **Licensed/Certified** Health Care Professional who has knowledge about the applicant’s functional ability. Part B be must be returned with Part A.

Applicant’s Name _____

Required Information – Licensed/Certified Health Care Professional

Name _____

Signature **X** _____ Date _____

Professional Title _____

Area of Professional Specialization _____

Professional License # _____

Clinic or Agency _____

Address _____

Phone Number _____

Questions Regarding the Applicant’s Disability – Please complete all sections that apply. Incomplete applications will be returned to applicant.

General Medical or Physical Disability Information

Applicant has been a patient of mine since: _____

Date of applicant's last evaluation: _____

18. Please indicate the nature of your patient's condition or disability. This list is not all inclusive; it lists what we predominantly see on submitted applications.

- Diabetes
- End Stage Renal Disease
- Dialysis? Yes No When? _____
- Undergoing Cancer Treatment Expected Duration: _____
- Arthritis: Please specify type and area(s)
- Amputation: Please specify extremity and/or use of prosthesis: _____
- Neurological Condition/Cognitive:
(Select One): Mild Moderate Severe Profound
- Neuromuscular Condition
- Pulmonary Disease: If on oxygen, what is the usage: _____
- Cardiac Disease Paralysis
- Mental Illness Dizziness
- Traumatic Brain Injury Shortness of Breath
- Legally Blind Need for Catheter
- Severally Visually Impaired Obesity/Weight
- Alzheimer's Autism
- Dementia
- Hearing Impairment: Specify degree of hearing loss: _____
- Seizure Disorder: Type(s) of seizures? _____

How often do the seizures occur? _____

After a seizure, how long does it take before the applicant is able to function safely?

Are the seizures preceded by an aura? Yes No

What triggers the applicant's seizure? _____

Is the applicant taking medication for the seizures? Yes No

Are the seizures currently controlled? Yes No

Is he/she able to function safely and effectively in the community?

Yes No

When was the applicant's last seizure? _____

Other _____

19. Is the condition(s) temporary? Yes No

If temporary, what is the expected duration? _____

20. Are there environmental conditions that would have a negative impact on the applicant's condition(s)? Yes No

What are the conditions? _____

What is the impact? _____

21. Do you feel the applicant could be trained to independently use regular city buses safely and effectively?

Yes No If no, why? _____

22. How far do you feel the applicant could independently propel a wheelchair or ambulate with or without a mobility aid and without lengthy rest breaks?

No independent functional mobility Blocks (500 ft. = 1 block)

Independently ambulate/wheel $\frac{3}{4}$ mile with brief rest periods if needed

23. How long can applicant wait at a bus stop with a bench/shelter? _____

24. How long can applicant wait at a bus stop without a bench/shelter? _____

Cognitive Disability

1. What is the formal diagnosis of the applicant's condition?

2. Does the applicant have any specific behavioral problems? Yes No

If yes, describe: _____

3. Is the applicant able to travel alone? Yes No

4. Does the applicant able to travel alone? Yes No

1 Step Directions 2 Step Directions 3 Step Directions None

5. Would the applicant know what to do if he/she became lost while out in the community? Yes No

6. Would the applicant be able to recognize and avoid dangers he/she might encounter when traveling in the community?

Yes No If no, explain: _____

7. Does the applicant have the ability to safely cross streets? Yes No

8. Please check all that apply to applicant and provide additional information, if necessary:

- | | |
|---|--|
| <input type="checkbox"/> Problem Solving | <input type="checkbox"/> Short-term Memory |
| <input type="checkbox"/> Attention | <input type="checkbox"/> Processing |
| <input type="checkbox"/> Foresight/Planning | <input type="checkbox"/> Safety Awareness/Judgment |

How would these prevent the applicant from being able to safely use regular city buses?

Behavioral Health

1. What is the formal diagnosis of the applicant's condition? _____

2. What is the prognosis for this condition for independent function? _____

3. Has the applicant been prescribed medications for his/her condition?

- Yes No

If yes, does this application allow the applicant to function safely in the community?

- Yes No

4. Has the applicant recently had a decline in function due to an adjustment in medication? Yes No

5. Does the applicant experience auditory or visual hallucinations? Yes No
If yes, how do the hallucinations impair the applicant's ability to function in the community? _____

6. Does the applicant have anxiety or panic attacks in closed/crowded spaces?

- Yes No

If yes, please explain: _____

7. Are there life skills that the applicant lacks that would prevent him/her from safely using regular city buses? Yes No If yes, please explain:

Vision Disability

1. What is the formal diagnosis of the applicant's condition? _____

2. Best Corrected Vision: _____

3. What is the prognosis? Is this condition stable, degenerative or otherwise changing? _____

4. Is the individual able to walk outdoors alone? Yes No

If yes, where can the applicant walk?

- Only on his/her own property and to familiar places
- To places nearby (for example, on the same block)
- To places further away

5. If applicant is able to travel outdoors alone, is he/she able to cross streets without help?

- At quiet streets with very little traffic
- At busy intersections
- Other
- At traffic lights
- With auditory cross signals only

If applicant is partially sighted:

6. Is he/she able to see steps or curbs? Yes No

7. Is his/her vision affected by different lighting conditions?

- Bright sunlight
- Dimly lit or shaded places
- Nighttime
- Other

8. Is the applicant's ability to travel outside alone affected other conditions?
(Consider impact of environmental noise and ability to distinguish traffic
flow patterns.) Yes No

Please explain: _____

Is there any other information you want to provide that will help us in making an
appropriate eligibility determination? _____

