GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES

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

Office of Public Transportation Telephone: (340) 773-1664 Ext. 4225

VITRAN Paratransit Plus ADA Service Application

Please note that any information given on this application will be kept confidential and shared only with professionals involved in providing the paratransit service on an as needed basis.

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 the time. Your ability to ride Fixed Route buses (regular city buses) will be evaluated using this application, an in-Person interview, and a functional assessment. FTA Requirement: "If, by a date 21 days (calendar) following the submission of a complete application, the entity has not made a determination of eligibility, the applicant shall be treated as eligible and provided service until and unless the entity denies the application" (§ 37.125(c)).

***Please be sure to contact the Division of Transportation at the Department of Public Works to schedule an in-person interview at 773-1664, Ext. 4225. 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. **If you are Hearing Impaired and need assistance, please call 1-800-809-8477 or 711**.

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.

ADA Paratransit Services Application

To ensure your application is processed in a timely manner, **all questions** must be answered. . ***Be sure to include a clear copy of a government issued photo ID.** **Part A and Part B must be submitted at the same time**. Incomplete applications will be returned to applicant and/or individual/agency completing application. All information is kept confidential. **Primary Language** ***(please check):***
____ **English** _____ **Other** ***(specify)***: _____. If information is required in an alternative format, please contact our office at: 340-773-1664, Ext. 4225. **If you are Hearing Impaired and need assistance, please call 1-800-809-8477 or 711**.

Date: _____

Part A: General information regarding applicant:

Check one: Mr.☐ Mrs.☐ Ms.☐
To be completed by applicant or on behalf of applicant.

☐ **New Applicant** ☐ **Renewal of Certification**

Name: _____
(Last) (First) (Middle)

Date of Birth: Year _____ Month _____ Day _____

Physical Address: _____

Name of Dev./Bldg.#_____ Apt./Rm.# _____

City _____ State _____ Zip _____

Instructions to Home: _____

_____

_____

Mailing Address, if different: _____
Island _____ Zip Code: _____
Telephone #: Home _____Work:_____
Email address: _____

Emergency Contacts: #1- Name _____ Phone #_____
Relationship _____

#2 - Name _____ Phone # _____
Relationship:_____

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?

   □ None
   □ Walker
   □ Service Animal
   □ Prosthetic Leg
   □ Power Scooter
   □ Segway
   □ Portable Oxygen
   □ Straight Cane
   □ White Cane
   □ Crutches
   □ Manual Wheelchair
   □ Rollator
   □ Leg Brace
   □ Other (*Be Specific*) _____
   □ Ride in a Car
   □ Alphabet/Picture Board
   □ Power/Electric Wheelchair

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

5. Will you be traveling with a Personal Care Assistant (PCA) when you travel?
   □ 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?_____

Applicant: _____

9. Describe the terrain/landscape 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 recognize your destination or landmark near your destination?
□ Yes □ No □ Sometimes

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? _____
_____
_____
_____

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 □ Other: _____

□ 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?_____

19. Is the applicant's medical condition(s) temporary? □ Yes □ No
    If temporary, what is the expected duration? _____

20. Due to the medical condition, is the applicant able to travel alone? □ Yes □ No

21. 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? _____
    _____

22. Do you feel the applicant could be trained to independently use regular city buses safely and effectively?
    □ Yes □ No If no, why? _____

23. 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 ¾ mile with brief rest periods if needed

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

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

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 _____

(Updated June 2021)

Relationship to Applicant :_____

Agency Name _____

Applicant: _____

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

____ Rehabilitation Specialist
____ Social Worker
____ Respiratory Therapist
____ Oncologist
____Psychologist
____ Psychiatrist
____Audiologist
____ Independent Living Specialist
____ Orientation & Mobility Instructor (O&M)
____ Physician
____ Physician Assistant (PA)
____ Podiatrist
____ Nurse (Practitioner/RN/LPN)
____ Physical Therapist
_____Optometrist/Ophthalmologist
____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 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.

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
   □ 1 Step Direction □ 2 Step Directions □ 3 Step Directions □ None

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

5. Would the applicant be able to recognize and avoid dangers he/she might encounter when traveling in the community?
   □ Yes □ No If no, explain: _____

6. Can the applicant safely cross streets? □ Yes □ No

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

□ Problem Solving
□ Attention
□ Foresight/Planning
□ Short-term Memory
□ Processing
□ 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/crowed 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
   □ Nighttime
   □ Dimly lit or shaded places
   □ 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? _____
_____
_____
_____