

# **APPLICATION AND CERTIFICATION FOR DISABLED FIXED-ROUTE HALF-FARE CERTIFICATION CARD**

## **INSTRUCTIONS**

- Applicant, Guardian, or Preparer completes Applicant's section and signs certification.
- An applicant must meet at least one of the definitions of disabled set forth on page 3 of this application to be eligible for a Disabled, Fixed-Route, Half-Fare Certification Card.
- Have a Physician complete 'Physician Section' and sign certification.
- Return completed application to:

Putnam County Department of Planning,  
Development, and Public Transportation  
841 Fair Street  
Carmel, NY 10512  
Fax #: (845) 878-6721

*Website: [www.putnamcountyny.com](http://www.putnamcountyny.com)*

- Note: Incomplete applications will not be considered. All Questions must be answered or answered with "Not Applicable" (NA) if question does not apply.
- If you have any questions in completing this form, please call any of the following numbers:

(845) 878-3480  
(845) 878-7433  
TDD: (845) 878-4039

**APPLICATION AND CERTIFICATION FOR  
DISABLED FIXED-ROUTE HALF-FARE  
CERTIFICATION CARD**

**APPLICANT'S SECTION**

1. Name \_\_\_\_\_  
Social Security Number \_\_\_\_\_

2. Address: \_\_\_\_\_  
\_\_\_\_\_ Zip: \_\_\_\_\_

3. Telephone No. (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_ Male  Female

5. Please provide the name of someone you would like us to contact in case of an emergency.

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

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

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

**CERTIFICATION**

I hereby certify, under penalty of perjury that all statements made on this application are true, to the best of my knowledge, and I authorize the completion of the remainder of this form by the appropriate professional and the release of any medical information necessary to process this application. I have read and understand, to the best of my knowledge, all the information contained in this application. I understand, to the best of my knowledge, that all statements made in this application may be subject to investigation and verification. I understand, to the best of my knowledge, that the COUNTY OF PUTNAM will rely upon the statements made in this application whether or not the COUNTY OF PUTNAM has investigated the statements contained in this application. I understand, to the best of my knowledge, that the COUNTY OF PUTNAM may discontinue or change its half-fare program without notice. If the COUNTY OF PUTNAM should find that I have not followed the program's guidelines, my half-fare services will be taken away and I will not be eligible to reapply for the half-fare program. I understand, to the best of my knowledge, that it is a crime to allow anyone else to use my identification card

*(continued)*

or for me to continue to use the card if I am no longer disabled as defined by the half-fare program. I agree to notify the Putnam County Planning Department at (845) 878-3480: TDD (845) 878-4039 if I no longer need half-fare privileges.

I hereby certify, to the best of my knowledge, that the information given is correct.

\_\_\_\_\_  
(Signature of Applicant or Legal Guardian)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print Name of Applicant or Legal Guardian)

**PREPARER:** If application has been prepared by a person who is not the applicant or a legal guardian, please complete the following:

Signature of Preparer: \_\_\_\_\_ Date: \_\_\_\_\_

Name (Print): \_\_\_\_\_

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

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

## PHYSICIAN SECTION

I, \_\_\_\_\_ am a physician licensed to practice under  
(print name of physician)  
the laws of the State of New York. It is my medical opinion that the applicant identified on this form is a “disabled person” within the meaning of that term as set forth by the definitions below:

**Please check one:**

\_\_\_ **Blind:** Having central visual acuity of 20/200 or less in the better eye with the use of correcting lens, whose peripheral vision is limited to a level of ten degrees. (Putnam County will accept the New York State Commission for the Blind and Visually Handicapped’s Certification of Blindness in lieu of a separate medical examination).

\_\_\_ **Deaf:** Complete Lack of bone conduction in both ears or a hearing loss of 80 decibels or greater as verified by audiometric testing.

\_\_\_ **Ambulatory Disability:** The person is unable to move about without the aid of a wheelchair, walker, crutches, or a cane, or:

- The person suffers from a heart or respiratory ailment which makes it impossible or inadvisable to walk for long distances, or:
- The person has an obvious and serious disorder of gait, which substantially interferes with the use of mass transportation facilities.

\_\_\_ **Developmental Disability:** A handicapping condition originating before age 22 and continuing indefinitely which is attributable to Cerebral Palsy, Autism, Neurological Impairment, Mental Retardation, or Epilepsy.

\_\_\_ **\*Mentally Retarded:** The person has an IQ of 69 or less or has a physical or mental impairment resulting in restriction of function. The county of Putnam will accept a certificate from an accredited institution for treatment or education of the mentally retarded.

**\*As determined by the Stanford-Binet, W.I.S.C., W.A.I.S., or conversion of the Raven Progression Matrices.**

\_\_\_ **Mental Illness:** The person has a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person so afflicted requires care, treatment, and rehabilitation by psychiatrist or psychologist in a mental hospital or certified day program.

**Is the disabling condition, checked above, permanent?**

Yes \_\_\_ No \_\_\_ If no, how long will the condition last: \_\_\_\_\_

Physician: \_\_\_\_\_  
(Signature) (License Number) (Telephone No.)