PART

APPLICATION FOR ADA PARATRANSIT ELIGIBILITY

APPLICANT INSTRUCTIONS

- Applicant, Guardian, or Preparer complete Part I and sign application and certification.

- Have appropriate Professional complete Parts II, III, or IV and have Professional sign certification.

- Return completed Application to:

  Putnam County Department of Planning,
  Development, and Public Transportation
  841 Fair Street
  Carmel, NY 10512
  Fax: (845) 808-1948 (original to follow in mail)

- NOTE: Incomplete applications will not be considered. All questions must be answered or answered with not applicable (N/A) if question does not apply.

- If you have any questions when completing this form, please call any of the following numbers:

  (845) 878-3480
  (845) 878-7433

For the Hearing Impaired please use the 711 Relay Service

Website: www.putnamcountyny.com

PART I. Questions 1-17 To Be Completed by the Applicant
(Type or Print Clearly)

Please answer the following questions as completely as possible, if a question does not apply to you, clearly mark N/A in the answer space provided:

1. Name: _____

   Last 4 digits of SSN: _____

2. Address: _____

   City:_____State: _____Zip:_____

   Nearest Intersection: _____

3. Telephone Number (home): _____(cell or 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:_____City/State:_____Zip:_____

   Telephone (home): _____ (work):_____

6. What is the disabling condition(s) which prevents you from using our fixed-route bus service?

   _____

   _____

7. How does this disability prevent you from using regular bus service?
   Please explain completely. Use an additional sheet if needed:

   _____

   _____

   _____

8. Are there any other effects of your disability of which we need to be aware?

   _____

   _____

9. Do you use any of the following mobility aides? *(Check all that apply)*

__ Wheelchair	__ Service Animal
__ White Cane	__ Crutches
__ Walker	__ Electric Scooter (i.e. Amigo, Rascal, etc.)
__ Personal Care Attendant	__ Braces
__ Cane	__ Other (describe): _____

10. Have you ever received travel training? *Yes* __ *No*__

a) Agency that trained you: _____

b) Was the training successfully completed? _____

c) Are there any limitations to your travel training?

Please explain: _____

_____

11. Can you understand printed or verbal transportation information such as bus schedule information (including TDD, audiotape or large print?)

Please explain: _____

_____

12. Can you calculate the correct fare and place it in the fare box? *Please explain:*

_____

_____

13. Can you locate seats or hand rail stanchions within the bus? *Please explain:*

_____

_____

14. What circumstances that relate to your disability would make it difficult for you to reach your destination after getting off the bus? *Please explain:*

_____

_____

15. Are you using the paratransit service to attend programs provided by an Agency? *Yes*__ *No*__ *If yes, please answer the following*:

a) What is the name of the agency that is sponsoring the program or services you will be attending?

Name of Agency: _____

Address: _____

_____

Phone#: _____ Contact Person: _____

b) Does the agency provide transportation? *Yes* __ *No* __

c) Are you eligible for that transportation? *Yes*__ *No* __

16. How did you find out about our paratransit service? *(Check all that apply)*

__ T.V. __ Planning Department

__ Newspaper __ Professional

__ Radio __ Service Provider

__ PART Employee __ Other:_____

17. Are you enrolled for Medicaid? *Yes*__ *No*__

a) Please give Medicaid #:_____

b) What type of transportation have you been approved for by Medicaid?

__ public bus __ taxi __ ambulette __ ambulance

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. 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 paratransit program without notice. If the COUNTY OF PUTNAM should find that I have not followed the program's guidelines, my paratransit services will be taken away and I will not be eligible to reapply for the paratransit program. I understand, to the best of my knowledge, that it is a crime to allow anyone else to use my identification card or for me to continue to use the card if I am no longer disabled as defined by the paratransit program.

I agree to notify the Putnam County Department of Planning, Development, and Public Transportation at *(845) 878-3480* if I no longer need paratransit service.

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

Signature of Applicant or Legal Guardian:_____
Print Name of Applicant or Legal Guardian: _____
Date Signed: _____

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

Signature of Preparer: _____
Print Name of Preparer: _____
Dated Signed: _____
Address: _____
City/Town: _____ State: _____ Zip:_____
Phone #: _____

PROFESSIONAL CERTIFICATION INSTRUCTIONS

***Dear Doctor*:**
The applicant who has asked you to complete and sign this form is applying for eligibility on the PART Paratransit service. Please read the following information carefully since it may affect your response.

Who Qualifies for Paratransit?
Paratransit service is designed to serve those persons whose severity of disability prevents them from using public transportation. Under the Americans with Disability Act (ADA), disability alone does not qualify a person to ride Paratransit. A person must be FUNCTIONALLY unable to use the fixed-route bus service. Service is provided to the following three general groups of persons with disabilities:

1. Persons who have specific impairment-related conditions which make it **IMPOSSIBLE** - not just difficult - to travel to or from a bus route location point.
2. Persons who need a wheelchair lift and a wheelchair lift-equipped bus is not available on the route when they need to travel.
3. Persons who are unable to board, ride, or exit from a PART bus even if they are able to get to a location point on the route and the bus is equipped with a wheelchair lift.

What is Paratransit?
Paratransit is an alternative, origin-to-destination, demand-responsive service. It is designed to "complement" the fixed-route service in terms of times and areas.

Origin-to-Destination provisions of ADA mean that **ASSISTANCE** is provided individuals between the door of their starting point or destination and the paratransit vehicle. In addition, paratransit is only required to provide service if both the starting and destination points are within ¾ of a mile of a fixed-route bus route during the hours when that route is in operation.

PART II: to be completed by a Medical Doctor for a physically handicapped person.

PART III: to be completed by an Ophthalmologist or Optometrist for a visually handicapped person.

PART IV: to be completed by a Psychiatrist or Medical Doctor for a mentally handicapped person.

(Please complete the appropriate form)

PART II: Questions 18-27 to be Completed for the <u>Physically Handicapped</u> Person by a Medical Doctor. (TYPE OR PRINT CLEARLY)

Name of Applicant: _____

18. Medical Diagnosis of handicapping condition: _____
_____
_____

19. Is this condition temporary? ___Yes ___ No (If yes, Expected duration until: _____)
20. Is this condition likely to become worse? ___ Yes ___ No
21. Is this person able to walk without the assistance of another person:
    a) 200 feet? ___ Yes ___ No ___ Only with great difficulty.
    b) ¼ mile? ___ Yes ___ No ___ Only with great difficulty.
22. Is this person able to climb a 16" step and two 10" steps?
    ___ Yes ___ No ___ Only with great difficulty.
23. Is this person able to wait outside without support for 10 minutes?
    ___All of the time; ___ Some of the time; ___ Not at all!
24. Is this person able to ride in an automobile (including getting in and out?)
    ___ All of the time; ___ Some of the time; ___ Not at all!
25. Does this person require the use of the following:

__ Wheelchair	__ Service Animal
__ White Cane	__ Crutches
__ Walker	__ Electric Scooter (i.e. Amigo, Rascal, etc.)
__ Personal Care Attend.	__ Braces
__ Cane	__ Other (describe): _____

26. Is there any other effect of the condition of which Putnam County should be aware?
(Please describe): _____
_____
_____
_____

27. **CERTIFICATION**

Please review the medical information provided in the application and fill out the certification as is appropriate and sign the document. The information you provide will help us to serve those who most need paratransit.

I, _____ certify _____
(Print Name of Physician) (Print Name of Patient)

to be a disabled person and that the medical information provided in the application is accurate to the best of my knowledge and is consistent with the applicant's medical diagnosis.

Signed this _____ *day of* _____*, 20*__

Signature of Physician: _____
Print Name of Physician: _____
License Number: _____
Address: _____
_____
Telephone No.: _____

PART III: Questions 28-34 to be Completed for the <u>Visually Handicapped</u> Person by a Medical Doctor, Ophthalmologist, or Optometrist. (Type or Print Clearly)

Name of Applicant: _____

28. Medical diagnosis of handicapping condition: _____
_____
_____
_____

29. Is this condition temporary?
___ Yes ___ No (If yes, Expected duration until: _____)

30. Is this condition likely to become worse? ___ Yes ___ No

31. Visual Acuity: ***Right Eye: ____/____ Left Eye: ____/____***

32. Visual Field: ***Right Eye:*** *Horizontal_____* ***Left Eye:*** *Horizontal_____*
Vertical _____ *Vertical _____*

33. Is there any other effect of the condition of which Putnam County should be aware?
Please describe: _____

_____

_____

34. <u>CERTIFICATION</u>

Please review the medical information provided in the application and fill out the certification as is appropriate and sign the document. The information you provide will help us to serve those who most need paratransit.

I, _____ certify _____
(Print Name of Professional) (Print Name of Patient)

to be a disabled person and that the medical information provided in the application is accurate to the best of my knowledge and is consistent with the applicant's medical diagnosis.

Signed this _____ day of _____, 20__

Signature of Professional: _____
License Number: _____
Address: _____
_____
Telephone No.: _____

PART IV: Questions 35-41 to be completed for the <u>Mentally Handicapped</u> Person by a qualified Medical Doctor or Psychiatrist. (Type or Print Clearly)

Name of Applicant: _____

35. Medical diagnosis of handicapping condition: _____
_____
_____

36. How does this condition affect the individual's ability to use fixed-route bus service?
_____
_____

37. Is this person able to:
    a) give address and telephone number on request ___ Yes ___ No
    b) recognize streets and bus numbers ___ Yes ___ No
    c) sign his/her name ___ Yes ___ No
    d) deal with an unexpected situation ___ Yes ___ No
    e) ask for and understand directions ___ Yes ___ No

38. Is this condition:
    a) Temporary? ___Yes ___No. If yes, expected duration_____
    b) subject to significant improvement with treatment? ___ Yes ___ No
    c) likely to become worse? ___ Yes ___ No

39. Should this person be accompanied while using Putnam County Paratransit Service?
    ___ Yes ___ No

40. Is there any other effect of the condition of which Putnam County should be aware?
    Please describe: _____
    _____

41. <u>CERTIFICATION</u>
    Please review the medical information provided in the application and fill out the certification as is appropriate and sign the document. The information you provide will help us to serve those who most need paratransit.

    I, _____ certify _____
    (Print Name of Professional) (Print Name of Patient)
    to be a disabled person and that the medical information provided in the application is accurate to the best of my knowledge and is consistent with the applicant's medical diagnosis.

    Signed this _____ day of _____, 20__

    Signature of Professional: _____
    License Number: _____
    Address: _____
    Telephone No.: _____