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

• Translation services available upon request.

Website: www.putnamcountyny.com/transportation
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 Physically Handicapped 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 Visually Handicapped 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


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. 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 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 Mentally Handicapped 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. 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 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.: __________________________________________

Name of Applicant: _____________________________________