COUNTY OF ORANGE

APPLICATION FOR PARATRANSIT SERVICES FOR PEOPLE WITH DISABILITIES

The Americans with Disabilities Act of 1990 (ADA) requires that public entities operating local, fixed-route bus service for the general public also provide complementary (meaning "in addition to") paratransit (wheelchair lift-equipped, origin-to-destination) service to persons unable to use the local, fixed-route bus system. This service will only be provided for those individuals whose trips begin and end within 3/4 of a mile of an existing local fixed-route bus line. To qualify to use this service you must obtain an approval letter from the County of Orange. Any individual is eligible to submit an application for the ADA Paratransit service if he or she feels he or she qualifies for the service. A copy of the definition of disability as it applies to paratransit service is included on the next page. Please note, however, that service will only be provided within the 1 1/2 mile corridor defined above. As of January, 2018 the local fixed-route bus systems that qualify for complementary paratransit service are those operated by Hudson Transit Lines, Newburgh Beacon Bus Corp., and the Village of Kiryas Joel. All applicants should proceed as follows:

1. Fill out Part I of this form. Part I must be completed for all applicants.

2. Have a qualified professional (as required in Part II, III, or IV) familiar with your disabling impairment complete either Part II, Part III, or Part IV of this form. Part II should be completed for persons with physical disabilities; Part III should be completed for persons with visual disabilities; Part IV should be completed for persons with mental disabilities. Part II, Part III, or Part IV must be completed for all applicants.

3. **Return the completed form to:**

   Orange County ADA Paratransit Service
   c/o Orange County Department of Planning
   124 Main Street
   Goshen, New York 10924

When received your application will be promptly reviewed. If your application is approved, you will be notified by letter within twenty one (21) days of its receipt. Your notice of approval will include information on how to use the complementary paratransit service. If your application is not approved you will be notified of the appeal process. On appeal you will have an opportunity to provide additional information for reconsideration by the Appeals Board.

The County of Orange requires the information contained in this form in order to:

1. Determine whether you require specialized transportation.
2. Provide specialized service appropriate to your needs; and
3. Be aware of any other special needs you may have.

Any questions about this application form, including who is eligible to sign off on Parts II, III, or IV, should be directed to:

Transit Orange
Orange County Department of Planning
124 Main Street
Goshen, New York 10924
Phone: (845) 615-3850
Fax: (845) 291-2533

The signature of the applicant on Part I authorizes the release of information to the County of Orange and the vendor contracted by the County of Orange to provide ADA Paratransit service. This information will be used solely to determine ADA paratransit eligibility; it will not be released to any other person or agency.

.....

DISABILITY means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment.

(1) The phrase **physical or mental impairment** means -

(i) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory including speech organs, cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin, and endocrine;

(ii) Any mental or psychological disorder, such as intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disabilities;

(iii) The term **physical or mental impairment** includes, but is not limited to, such contagious or noncontagious diseases and conditions as orthopedic, visual, speech, and hearing impairments; cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disability, emotional illness, specific learning disabilities, HIV disease, tuberculosis, drug addition and alcoholism.

(iv) The phrase **physical or mental impairment** does not include homosexuality or bisexuality.

(2) The phrase **major life activities** means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

(3) The phrase **has a record of such an impairment** means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

(4) The phrase **is regarded as having such an impairment** means -

(i) Has a physical or mental impairment that does not substantially limit major life activities, but which is treated by a public or private entity as constituting such a limitation;

(ii) Has a physical or mental impairment that substantially limits a major life activity only as a result of the attitudes of others toward such an impairment; or

(iii) Has none of the impairments defined in paragraph (1) of this definition but is treated by a public or private entity as having such an impairment.

(5) The term **disability** does not include -

(i) Transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders;

(ii) Compulsive gambling, kleptomania, or pyromania;

(iii) Psychoactive substance abuse disorders resulting from the current illegal use of drugs.

PART I: TO BE COMPLETED BY THE APPLICANT
(Type or print clearly)

The information on this form will be used only by the County of Orange and the vendor contracted by the County of Orange to provide ADA Paratransit service and will not be provided to any other person or agency.

1. Name _____ Sex: M / F

2. Home Address _____

   _____

3. Telephone Number (Home) _____ (Work) _____

4. Emergency Contact Name & Phone #_____

5. Date of Birth _____/_____/_____

6. Is this application for a ____ temporary or ____ permanent status?

7. What is the physical, visual, or mental condition(s) which prevent(s) you from using fixed-route bus service?

   _____

   _____

8. How does this condition(s) prevent you from using fixed-route bus service? Please explain completely.

   _____

   _____

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

   Manual Wheelchair ____ Electric Wheelchair ____

   Walker____ Cane ____ Crutches ____

   Aide/Helper ____ Service Animal ____

I hereby certify that the information given above is correct and I authorize the completion of the remainder of this form and release of the form and related information to the County of Orange and the vendor contracted by the County of Orange to provide ADA Paratransit service.

It is my understanding that this information will be used solely to determine ADA complementary paratransit eligibility and not for any other purpose. The information contained in this application will not be released to any person or agency other than the County of Orange and the vendor contracted by the County of Orange to provide ADA Paratransit service.

_____ _____

Signature of Applicant **Date**

PART I
(Continued)

10. If someone other than the applicant completed this form on behalf of the applicant, that person must complete the following:

Name _____

Agency_____

Address _____

_____

_____

Phone Number_____

_____ _____
Signature Date

PART II: TO BE COMPLETED FOR THE PERSON WITH A PHYSICAL DISABILITY
(Type or print clearly)

Questions 11-19 must be completed by a licensed medical doctor or a registered physical or occupational therapist.

11. Medical diagnosis of the handicapping condition (Please include ICD10 Code):_____
_____
_____
_____
_____

12. Is this condition temporary? Yes ____ No ____ (Expected duration until:_____)

13. Is this condition likely to become worse? Yes ____ No ____

14. Is this person able to walk without the assistance of another person:
    A. 200 feet? Yes ____ No ____ Only with great difficulty ____
    B. 1/4 mile? Yes ____ No ____ Only with great difficulty ____
    C. 3/4 mile? Yes ____ No ____ Only with great difficulty ____

15. Is this person able to climb three (3) 12" steps using a handrail?
    Yes ____ No ____ Only with great difficulty ____

16. Is this person able to wait outside without physical support for 10 minutes?
    All of the time ____ Some of the time ____ Not at all ____

17. 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 ____

18. Does this person require the use of the following:
    A. Wheelchair
       All of the time ____ Some of the time ____ Not at all ____
    B. Cane, Crutches or Walker
       All of the time ____ Some of the time ____ Not at all ____
    C. Prosthesis
       All of the time ____ Some of the time ____ Not at all ____
    D. Aide/Helper
       All of the time ____ Some of the time ____ Not at all ____

PART II
(Continued)

19. The name and signature below should be that of a licensed medical doctor or registered physical or occupational therapist.

Name _____

Specialty_____

Title and Agency_____

Office Address _____

_____

Office Telephone Number _____

_____ _____
Signature Date

_____
Professional License Number

PART III: TO BE COMPLETED FOR THE PERSON WITH A VISUAL DISABILITY
(Type or print clearly)

Questions 20-25 must be answered by an licensed ophthalmologist or optometrist.

20. Medical diagnosis of impairing condition (Please include ICD10 Code): _____
_____
_____
_____
_____

21. Is this condition temporary? Yes ____ No____ (Expected duration until: _____)

22. Is this condition likely to become worse? Yes ____ No ____

23. Visual acuity: Right eye ____/____ Left eye ____/____

24. Visual field: Right eye: Horizontal ____ Left eye: Horizontal ____
Vertical ____ Vertical ____

25. The name and signature below must be that of a licensed ophthalmologist or optometrist.

Name _____

Specialty _____

Title and Agency _____

Office Address _____

_____

Office Telephone Number _____

_____ _____
Signature Date

_____
Professional License Number

PART IV: TO BE COMPLETED FOR THE PERSON WITH A MENTAL DISABILITY

(Type or print clearly)

Questions 26-31 must be completed by a qualified and licensed medical doctor, psychiatrist, or psychologist.

26. Medical diagnosis of impairing condition (Please include ICD10 Code):

_____
_____
_____

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

_____
_____
_____

28. Is this person able to:
    - A. Give address and telephone number upon request? Yes____ No ____
    - B. Recognize streets and bus numbers? Yes____ No ____
    - C. Sign his/her name? Yes____ No ____
    - D. Ask for and understand directions? Yes____ No ____

29. Is this condition:
    - A. Subject to significant improvement with treatment? Yes ____ No ____
    - B. Likely to become worse? Yes ____ No ____

30. Should this person be accompanied while using door-to-door transportation service?
    Yes____ No____

31. The name and signature below must be that of a licensed medical doctor, psychiatrist, or psychologist.

Name _____

Specialty _____

Title and Agency _____

Office Address _____

_____

Office Telephone Number _____

_____ _____
Signature Date

_____
Professional License Number