City of Gloversville
3 Frontage Rd, Gloversville, NY 12078

GLOVERSVILLE TRANSIT SYSTEM
...transportation into the future

APPLICATION FOR GLOVERSVILLE TRANSIT SYSTEM PARATRANSIT SERVICE

INSTRUCTIONS

The Gloversville Transit System provides curb-to-curb transportation services for persons who are unable to rise to regular fixed route bus service as defined under the ADA guidelines. **Gloversville Transit Policy for ADA Paratransit**: No individual will be excluded from riding the paratransit bus if they travel with a certified service animal, oxygen tanks, personal care attendants, respirators or motorized wheelchairs.

Before you can access the Independent Travel Line you must:

1. Fill out Parts I and II of this form and sign where indicated.
2. Part III must be completed by a physician, ophthalmologist, optometrist, psychiatrist, or other medical professional such as a physical/occupational therapist.
3. Return form to either;

Gloversville Transit System 109 W. Fulton Street Gloversville, NY 12078	Gloversville Transit System 3 Frontage Rd, City Hall Gloversville, NY 12078

Gloversville Transit System will process your application within three (3) weeks and let you know if you are eligible for service. If you are found eligible for service, you will be given an identification card and information on how to use the paratransit service. If your application for service is denied, you will have an opportunity to appeal the decision.

Gloversville Transit System requires the information requested on this form in order to determine whether you require specialized transportation and provide service appropriate to your needs. The information on this form will be used only by Gloversville Transit System and will not be provided to any other person or agency.

If you have any questions about this form or the paratransit service, call Gloversville Transit System at 773-4528, Monday – Friday, 8:00am to 4:00pm.

Sincerely,

Brent R. Warren
Mobility Manager

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PART I: APPLICANT INFORMATION (TYPE OR PRINT CLEARLY)

NAME: _____

HOME ADDRESS: _____

_____

TELEPHONE: Home: _____ Cell: _____ Work: _____

If approved you will need service (initial one):

A. For all trips, all of the time _____
B. Only under certain conditions _____
   (i.e. bad weather)
C. During a temporary disability _____
   (Following surgery or recovering
   from and injury)

Indicate length of time you expect to need the paratransit service:
From _____ To _____

Can you ever use the Gloversville Transit System regular route bus stop? YES____ NO ____
If YES, under what conditions? Only in good weather ___. Only with a companion ___.
Other_____

How far do you live from the Gloversville Transit regular route stop?
Within, a block____, ¼ Mile____, ½ Mile____, ¾ Mile____, Further____.

What is the physical, mental or visual condition(s) which prevents you from using the Gloversville Transit's regular route bus service? _____
_____
_____
_____

How does the condition(s) stated above keep you from using the regular bus service?
_____
_____
_____

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Please indicate any other effects of the above condition(s) or other conditions the Gloversville Transit System should be aware of. _____

_____

_____

Do you use any of the following? Check all that apply:

Manual Wheelchair ☐ Electric Wheelchair ☐ Cane ☐ Crutches ☐
3-Wheel Scooter ☐ Guide Animal ☐ Service Animal ☐
Other _____

What are your current means of transportation? Check all that apply:

None Available ☐ Ride with Family ☐ Private Accessible Transit ☐
Special Transportation ☐ Taxi ☐ Agency Transportation ☐
Medical Transportation ☐ Other _____

Person that may be contacted in case of emergency:

Name:_____
Relationship:_____
Telephone: Home: _____ Cell: _____ Work: _____

I hereby certify that the information given above is correct and I authorize the completion of the remainder of this form and the release of the form and related information to the Gloversville Transit System.

Signature: _____ Date: _____

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

Name: _____
Address: _____
_____

Signature: _____ Date: _____

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PART II: RELEASE OF INFORMATION

To be completed by the applicant (TYPE OR PRINT CLEARLY)

In order to allow the Gloversville Transit System to evaluate your request, it may be necessary to contact a physician or other professional to confirm the information you provided on the application. Please complete the following information and authorization form.

The following physician ☐, qualified agency representative ☐, health care provider ☐, rehabilitation professional ☐, (Check one) is familiar with me disability and is authorized to complete this certification.

Name: _____

Address: _____

_____

Telephone: _____

Signature of applicant: _____ Date: _____

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PART III: VERIFICATION OF ELIGIBILITY (TYPE OR PRINT CLEARLY)

To be completed by a physician, ophthalmologist, psychiatrist; other medical professional (physical/occupational therapist); or qualified agency representative. The information supplied will be used to verify information given to the Gloversville Transit System by the individual requesting service. Because of this fact, your evaluation of this individual's condition(s) is most important. Thank you for your cooperation.

What is the medical diagnosis of the "transit disabling" condition of the applicant? Please describe briefly in lay terms: _____

_____

_____

Is this condition Temporary? YES ☐ NO ☐

If YES, expected duration: _____

Is this condition likely to become worse? YES ☐ NO ☐

In your opinion or from your observations, is this person able to walk without the assistance of another person: 200 Feet? YES ☐ NO ☐
¼ of a Mile? YES ☐ NO ☐

Is this person able to climb three (3) 15" steps using a handrail? YES ☐ NO ☐

Is this person able to wait outside, alone, for 10 minutes? YES ____ NO ____

Is this person able to ride in an automobile (including getting in and out independently)?
YES ____ NO ____

Is this person sight impaired to any degree? YES ____ NO ____
If YES, please explain the impairment: _____

Does this person require the use of any of the following:
Wheelchair: YES ☐ NO ☐ Some of the Time ☐
Cane, crutches, walker: YES ☐ NO ☐ Some of the Time ☐
Prosthesis: YES ☐ NO ☐ Some of the Time ☐
Guide or Service Animal: YES ☐ NO ☐ Some of the Time ☐

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Does this person have any other physical or mental conditions which the Gloversville Transit System should be aware of? Please describe: _____

_____

_____

_____

Is this person able to:

Give name and address on request? YES ☐ NO ☐
Recognize streets and bus numbers? YES ☐ NO ☐
Deal with unexpected situations? YES ☐ NO ☐
Ask for and understand directions? YES ☐ NO ☐

In your opinion, should this person regularly be accompanied by a responsible personal care attendant/companion while using Gloversville Transit System Paratransit, curb-to-curb bus service? YES ____ NO ____

The name and signature below should be that of the person completing the certification or eligibility form:

NAME: _____

TITLE: _____

OFFICE ADDRESS: _____

_____

_____

OFFICE PHONE: _____

SIGNATURE: _____ DATE: _____