



*City of Gloversville*

3 Frontage Rd, Gloversville, NY 12078

## **GLOVERSVILLE TRANSIT SYSTEM**

*...transportation into the future*

# **APPLICATION FOR GLOVERSVILLE TRANSIT SYSTEM PARATRANSIT SERVICE**

## **INSTRUCTIONS**

For a fee of \$4.00 each way (**Cash, Check or Ticket only**), Gloversville Transit System provides curb-to-curb transportation services for persons who are unable to ride the regular fixed route bus service as defined under 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 & 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	Gloversville Transit System
109 W. Fulton Street	3 Frontage Rd, City Hall
Gloversville, NY 12078	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 518-773-4528, Monday – Friday, 8:00am to 3:00pm.

Sincerely,

Brent R. Warren  
Transit Director/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 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 \_\_\_\_\_

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 \_\_\_ 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 (*check one*) physician \_\_\_\_, qualified agency representative \_\_\_\_, health care provider \_\_\_\_, rehabilitation professional \_\_\_\_, is familiar with my 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 (NOT THE APPLICANT), 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 (**NOT THE APPLICANT**):

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

OFFICE ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

OFFICE PHONE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_