F.A.M.E. Application for Paratransit Eligibility

(Freedom **A**nd **M**obility **E**xpress**)**

PART 1

Information obtained in this certification process will be used only by Greater Glens Falls Transit (GGFT) for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel. The information will not be provided to any other person or agency. Professional verification of disability is required.

(Please Print)

Name _____

Date of Birth _____ Telephone _____

Address _____

Nearest Intersection:_____

City _____ State _____ Zip _____

***In order to allow GGFT to evaluate your request, it may be necessary to contact a physician or other professional to confirm the information you have provided. Please complete the following information and authorization form.**

The following (please check one): ☐ Physician ☐ Health Care Professional ☐ Rehabilitation Professional is familiar with my disability and is authorized to provide information required to complete this certification to GGFT.

Name _____

Address

_____

City_____ State _____ Zip _____

Telephone #_____

Signature of Applicant:_____ Date:_____

If this application is being completed by someone other than the person requesting certification, that person must complete the following.

Name _____ Relation to Applicant _____

Address _____

City _____ State _____ Zip _____

Daytime Telephone _____

Signature _____ Date _____

PART 2

What is the disability that prevents you from using GGFT's fixed route transit service?

_____

_____

Is this condition temporary? Yes ___ No ___
If yes, expected duration until - _____ - _____- _____

Are you able to use a wheelchair accessible fixed route bus? Yes ___ No ___

If "No", how does your disability prevent you from using wheelchair accessible fixed route service? *Please explain completely. Use additional sheet if needed.*

_____

_____

How far do you live from the nearest bus line? _____

Are there any other aspects of your disability of which GGFT needs to be aware?

_____

_____

The following information will be used to ensure that an appropriate vehicle is utilized to provide your transportation and that an accurate analysis of your trip requests can be made by GGFT. Please check all that apply.

Do you use any of the following mobility aids?

☐ Manual Wheelchair ☐ Electric Wheelchair ☐ Powered scooter ☐ Cane ☐ Crutches ☐ Personal care attendant ☐ Service animal

Do you require a Personal Care Attendant when you travel using transit (**must be provided by the applicant**)?
Yes ___ No ___

Please answer the following:

Can you travel 200 feet without the assistance of another person?	Yes ___ No ___ Sometimes ___
Can you travel ¼ mile without the assistance of another person?	Yes ___ No ___ Sometimes ___
Can you climb three 12-inch steps?	Yes ___ No ___ Sometimes ___
Can you wait outside alone for 10 minutes?	Yes ___ No ___ Sometimes ___

- Please briefly explain each ***"Sometimes"*** selection.

_____
_____
_____

Who should GGFT contact in the case of an emergency? :

Name: _____

Daytime Phone #: _____

I hereby certify that the information given above is correct.

_____ _____

(Signature) (Date)

Please return this completed application to:

Greater Glens Falls Transit
495 Queensbury Ave.
Queensbury, NY 12804

Office use only:
Date application received by GGFT _____

Prof. Verif. Sent Yes/ No / Date sent _____ Date prof. Ver. Returned:_____

Application Approved by GGFT _____ Date:_____

Eligibility classification: _____

ID # _____ Expiration _____