Nassau Inter-County Express (NICE)
Application for Able-Ride Complementary Paratransit Service

Dear Applicant:

The Americans with Disabilities Act of 1990 (ADA) is a civil rights bill that prohibits discrimination against people with disabilities. The intent of ADA is to ensure that persons with disabilities who cannot use the regular fixed route bus have equal access to public transportation. The specialized transportation offered by Able-Ride is a curb-to-shared ride service for eligible individuals who are prevented from accessing, boarding or riding the regular fixed route bus service.

NICE is required by the ADA to determine eligibility for Able-Ride service.

Categories of eligibility for Nassau County's Able-Ride service are as follows:

- **Persons who are unable to board, ride, or disembark from a fixed route bus, regardless of their ability to get to a bus stop.**
- **Persons with specific impairments who cannot travel to a bus stop to board the fixed route bus, or travel to their final destination after disembarking from the fixed route bus.**

If you believe your disability may fit into one of the categories described above, you must apply for certification by completing the attached "Paratransit Application" form. In addition, a New York licensed professional (i.e., physician, physical/occupational therapist or social worker) who is familiar with your functional ability must verify your application.

Please remember that your age, disabilities or distance from a bus stop, **do not** automatically make you eligible for paratransit service.

In addition to completing this application you must submit one (1) recent photograph (measuring 2" inches in length X 1 . in width and taken within the last year). Please write your name on the back of the photograph. The photograph must have a solid background and show a full frontal view of your face. Your application will not be considered complete unless the photograph is included.

Your application will be considered complete once all questions have been answered, a photograph has been attached and your licensed/certified professional has completed Part B. Return this application to the NICE Able-Ride Certification Department. Able-Ride will provide a decision as to your eligibility within 21 days, once the completed application is received.

SERVICE AREAS

Nassau Inter-County Express is an origin to destination paratransit service for Nassau County servicing approximately two miles into Nassau/Suffolk County border.

Able Ride does **NOT** provide paratransit complementary service in the following areas:

Syosset, Bayville, Oyster Bay, Lido Beach, Point Lookout, Locust Valley and Sands Point.

Able Ride provides **PARTIAL** service in the following areas: Valley Stream, Woodmere, Old Bethpage, Hicksville, Long Beach, Glen Cove, Plainview and Lawrence.

Under the ADA Federal Guidelines the service areas are deemed in compliance when both pickup and drop off locations are within **¾ mile radius** of an N.I.C.E operating fixed route **BUS STOP**. The serviceable times are in accordance with the closest fixed route bus schedule.

If your pickup location (ex: home address) is not a serviceable location you may still utilize the paratransit service by using any address that fulfills the required ADA ¾ mile radius service rule. The applicant must however get him/her self to the serviceable pickup location by their own means.

If you are interested in traveling outside Nassau County borders please call 516-228-4000 for more information or go to www.nicebus.com

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If you have any questions regarding this application, please contact the NICE Able-Ride Certification Department at (516) 228-4000. Mail your application to:

NICE Able-Ride
947 Stewart Ave.
Garden City, NY 11530

PART A APPLICANT INFORMATION (PLEASE PRINT)

All the regular Nassau Inter-County Express (NICE) fixed route buses have wheelchair lifts and kneelers (steps that lower to the curb level) for ease of boarding and all make automatic stop and key location announcements.

Date:_____

Please check one: First Application____ Re-certification Application_____

Previous Certification ID # _____

Last Name_____ First Name_____ MI_____

Street Address_____

City_____ State_____ Zip Code_____

Home Phone Number ( )_____ Cell Phone Number ( )_____

Date of Birth_____ Male _____Female_____

Email Address for correspondence (Optional):_____

Emergency Contact Name:_____

Emergency Contact Phone Number:( )_____ Relationship_____

Closest bus stops to your residence. _____

_____

(If you are not sure, please call (516) 228-4000, use option 2)
Name of subdivision or apartment complex: _____

Nearest major intersecting street: _____

Nearest cross street to your residence: _____

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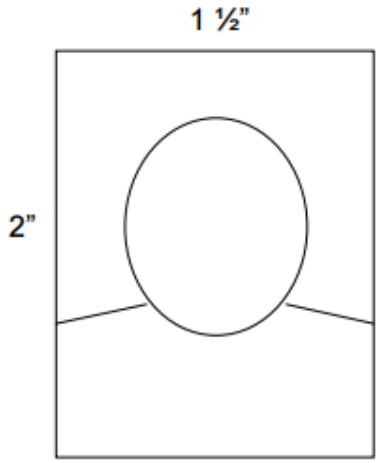
Please Attach Passport Type Photo Below:



List the Medical Names of Your Disabilities or Medical Conditions	Is the Condition Permanent?	Duration of Condition	Medications taken for the Condition

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1. Please describe how your physical or mental condition limit your ability to access the bus stop, ride the bus or transfer to another regular Nassau County Inter-County Express transit bus. Please be specific.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

2. Do you have a **Cognitive Disability**? (Have you ever been diagnosed with Traumatic/ Non-Traumatic Brain Injury, Mental Retardation, Borderline Intelligence, Down's syndrome, Autism, etc.?) Yes □ No □

3. Do you experience any of the following? Please check all that apply:

Panic Attacks		Easily Agitated or Angered	
Anxiety		Easily Wander Off	
Hallucinations		Seizures	
Delusions		Visual Impairment	
Paranoia		Short Term Memory Loss	
Confusion		Long Term Memory Loss	
Hear Voices		Cannot Identify Pictures	
Inappropriate Behaviors		Cannot Read or Write	
Easily Taken Advantage of by Others		Difficulty Understanding Written or Verbal Instructions	

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4. If you experience **Seizures**? Please check all that apply
□ Grand Mal □ Petit Mal □ Temporal Lobe □ Epileptic Lobe

5. When having a seizure, I: Please check all that apply:
□ Am Difficult to arouse □ Black out □ Fall Asleep
□ Need Immediate Medical Attention □ Stare Blankly into Space

6. How often do they occur? _____

7. Are you currently taking medication to control them? Yes □ No □

8. Do you have a **Visual Impairment** (to include Blindness)? Yes □ No □
If yes, please check all that apply:
□ I wear contacts or glasses.
□ I can recognize my stop if announcements are made.
□ I am legally blind and cannot distinguish my appropriate stop, disembark, and navigate the route to my destination. I do not use a guide dog or other service animal, or any assistive device.
□ I use a guide dog or other service animal, but I need paratransit to get to/from destinations that I cannot safely travel to on the route.
□ I can easily hear and recognize environmental sounds that help me to determine the traffic flow patterns.
□ I cannot easily hear environmental sounds that help me to determine traffic flow.
□ I cannot always get out of the roadway before the traffic signal changes.
□ I require a sighted guide to assist me with the following tasks:_____
_____
_____

9. Do you have a **Mental/Psychological Disability**? Yes □ No □ If yes, please state the disability and explain how if affects you. _____
_____
_____
_____
_____

10. Are there any other physical or mental disabilities that impact your **FUNCTIONAL ABILITY** to ride the regular fixed route, accessible bus service? (Example: difficulty with getting to the bus, waiting at the stop for the correct bus, boarding the bus, knowing when you get to your stop and notifying the driver that you need to get off.) Yes □ No □ if yes, please explain.
_____
_____

_____

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11. Can you wait 20 minutes at a NICE bus stop that **DOES NOT** have seats?
Yes □ No □ if no, please explain._____
_____
_____

12. Can you wait 20 minutes at a NICE bus stop that **DOES** have seats and a shelter?
Yes □ No □ if no, please explain._____
_____
_____

13. Can you wait 20 minutes at a NICE bus stop unassisted? Yes □ No □ If no, please explain._____
_____
_____

14. How far can you walk without the assistance of another person? Please check.
□ Less than one block □ 3-4 blocks □ Over 6 blocks
□ 1-2 blocks □ 5-6 blocks □ I don't know

15. Do you require a ramp or lift in order to board/exit the bus? Yes □ No □

16. Do you use a mobility device to travel? Yes □ No □ please check all that apply.
□ White Cane □ Orthopedic Cane (three or four prong base)
□ Standard Cane □ Walker □ Braces □ Crutches
□ Manual Wheelchair □ Motorized Wheelchair □ Scooter
□ Respirator/Oxygen □ Service/Guide Animal Describe: _____

17. What is the height/width of your unoccupied wheelchair/scooter?
Height _____Width _____

18. What is the weight of your wheelchair/scooter while it is occupied? _____

19. Do you require a personal care assistant (PCA) to travel with you to provide transportation assistance? Yes □ No □ If yes, please explain the specific assistance you require._____
_____
_____

20. If you do not require a personal care assistant for bus travel, are you required to be met by a caregiver when existing the bus? Yes □ No □

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21. If the bus arrives at your destination and the caregiver is not there to assist you off the bus, who must be contacted?
Name: _____
Telephone: _____
Please note: If the contact number is not answered or if the number is disconnected, Family Service or local police may be called to take custody of the passenger.

22. Are there situations when your caregiver will not be required to meet the bus?
Yes □ No □ If yes, please explain. _____
_____

23. How do you travel now? Please check all that apply.
□ Wheelchair/scooter □ Walk □ Drive myself
□ Passenger in someone else's car □ Other van service
□ Regular NICE fixed route bus □ Currently have no means of travel
□ NICE Paratransit Bus

24. Have you ever ridden a regular fixed route, accessible bus? Yes □ No □
If yes, when was the last time you rode a, regular fixed route accessible bus?
_____

25. Why did you stop using the regular fixed route, accessible bus? _____
_____
_____

26. Do you feel that you could ride the regular fixed route, accessible bus if the paratransit van could get you to/from an accessible bus stop? Yes □ No □ If no, Please explain how your disability restricts. _____
_____
_____

27. Please check all that apply to you:
□ I am able to board, ride, and exit a regular fixed route, accessible bus.
□ I can cross the street.
□ I can step on and off the sidewalk.
□ I can stand on a moving bus, holding the handrail, if no seat is available.
□ I can use a telephone to get bus schedule information.
□ I can find my way to the bus stop after being shown where it is based.
□ I can transfer to another bus or train after being shown where it is based.
□ I can hear and understand the automatic announcement system on the bus.
□ I need assistance understanding and navigating the fixed route system.
□ I do not have the stamina to travel long distances.

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Please explain those items checked above._____

_____

_____

_____

_____

_____

I have reviewed all the information contained in this application. I certify that all the information is true and correct to the best of my knowledge and ability. I understand that falsification of information may result in denial of service. I understand that only certain information may be kept confidential. This confidential information includes the specific diagnosis provided by the licensed professional, the nature of the disability provided by the applicant, and the applicant's day and month of birth. I understand that only the information required to providing paratransit services will be disclosed to those who perform those services. I understand that NICE may contact the licensed professional who has completed the Professional Verification Form (PART B) is attached to this application in order to confirm or clarify this information. I hereby authorize release of this medical information as requested by NICE for a period of 3 years from this date.

Applicant Signature: _____ **Date**: _____

If a person other than the applicant has completed this form, please check one of the following. **Please note that if you are a professional assisting your client you may not also verify Part B.**

□ I certify that the information provided in this application is true and correct based upon the information given to me by the applicant.
□ I certify that the information provided in this application is true and correct based upon my own knowledge of the applicant's health condition or disability.

Print Name: _____

Signature: _____

Relationship to Applicant: _____

Telephone: _____ (day) _____ (evening)

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PLEASE READ THIS APPLICATION AGAIN. ANSWER AND EXPLAIN EVERY QUESTION THAT APPLYS TO YOUR CONDITION TO THE BEST OF YOUR ABILITY AND INCLUDE ADDITIONAL INFORMATION IF NEEDED. IF YOU DO NOT ANSWER ALL THE QUESTIONS ON YOUR APPLICATION, PROVIDE A RECENT PICTURE AND HAVE A PROFESSIONAL VERIFY YOUR APPLICATION IT WILL BE RETURNED TO YOU. WE WILL PROCESS YOUR APPLICATION ONLY WHEN IT IS COMPLETE.

FAILURE TO DO SO WILL DELAY A DETERMINATION OF ELIGIBILITY.

PART B: LICENSED PROFESSIONAL VERIFICATION

Dear Licensed Professional:

The Americans with Disabilities Act (ADA) of 1990 is a civil rights bill prohibiting discrimination against people with disabilities. In accordance with the Act, Nassau Inter-County Express (NICE) offers a curb-to-curb bus service for those who cannot use the regular fixed route buses.

Passengers must be certified eligible in order to use the curb-to-curb bus service. Applicants may be found eligible for this bus service for some trip requests but not for all trips they request. Eligibility is based upon a functional inability to use the regular transit service.

Categories of eligibility for Nassau County's Able-Ride service are as follows:

- Persons who are unable to board, ride, or disembark from a fixed route bus, regardless of their ability to get to a bus stop.
- Persons with specific impairments who cannot travel to a bus stop to board the fixed route bus, or travel to their final destination after disembarking from the fixed route bus.

All regular fixed route buses are equipped with a ramp or lift for people who use a wheelchair or cannot climb stairs.

The information you provide, along with the applicant's information, will enable us to make an appropriate determination. All information will be kept confidential.

If you have completed Part A of this application you cannot also verify Part B. Persons completing Part B must be a licensed professional in the State of New York.

Thank you for your assistance.

Nassau Inter-County Express (NICE) Able-Ride

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PART B: LICENSED PROFESSIONAL VERIFICATION
Please make certain that responses are legible.

1. What disability or conditions prevents the applicant from riding the regular fixed route bus? Explain in **detail** the applicant's clinical diagnosis pertaining to physical, developmental, cognitive, visual or other disability.
_____
_____
_____
_____
_____
_____
_____

2. Is the condition temporary? □ Yes □ No

3. What is the expected duration of the condition? _____months

4. Is the applicant able to travel to and from the bus stop? □ Yes □ No

If No check all that apply:
□ Cannot negotiate in areas without sidewalks. □ Cannot negotiate steep terrain.
□ Cannot step on/off a curb. □ Cannot cross a busy intersection.

Cannot tolerate: □ Heat □ Cold □ Humidity □ Poor Air Quality
Cannot locate bus stop: □ Visually □ Cognitively
Cannot stand at a bus stop for: □ 10 minutes □ 20 minutes □ 30 minutes

5. Is the applicant able to accomplish the follow task without assistance?

Find his/her way between familiar locations □ Yes □ No

Grasp coins, passes, railings and handles □ Yes □ No

Signal the bus driver to get off the bus at the appropriate stop □ Yes □ No

Communicate important information upon request □ Yes □ No

Ask for, understand and follow directions □ Yes □ No

Travel 200 feet (1 city block) □ Yes □ No

Travel . mile (3 city blocks) □ Yes □ No

Travel . mile (6 city blocks) □ Yes □ No

Deal with unexpected situations □ Yes □ No

Safely travel through crowded facilities □ Yes □ No

6. Describe the applicant's visual impairment. Mark all that apply.
□ Totally Blind □ Legally Blind □ Glaucoma □ Macular degeneration
□Retinal Detachment □ Retinopathy □ Cortical Blindness □Cataracts
□Other: _____

7. Please Print Name and Title of Health Care Professional

Full Name: _____

Title: _____

Clinic/Business: _____

Street Address:_____

City: State: Zip Code: _____

Telephone: Fax No.:_____

E-mail (optional): _____

New York State Professional License, Registration or Certification Number:
_____

Agency Issuing License/Certification:_____

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I have reviewed all of the information contained in this application and hereby certify that all the information is true and correct to the best of my knowledge and ability. I certify that the applicant named herein, is under my professional care. I hereby swear and affirm that the applicant is disabled as indicated.

Signature of Licensed Professional: _____

Date: _____

Additional Comments:

_____

_____

_____

_____

_____

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