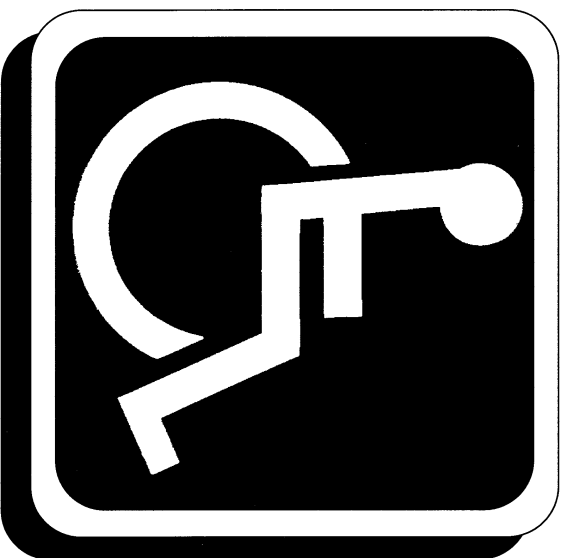




Suffolk County Office of Handicapped Services  
North County Complex, Bldg. 158  
Veterans Memorial Highway  
P.O. Box 6100  
Hauppauge, NY 11788-0099

**ACCESSIBLE TRANSPORTATION  
IDENTIFICATION CARD  
APPLICATION**

**SCAT/PARATRANSIT  
APPLICATION**



**STEVE LEVY  
SUFFOLK COUNTY EXECUTIVE**

**BRUCE G. BLOWER, DIRECTOR  
OFFICE OF HANDICAPPED SERVICES  
VETERANS MEMORIAL HIGHWAY  
BUILDING 158 NORTH COUNTY COMPLEX  
P.O. BOX 6100  
HAUPPAUGE, NY 11788-0099  
(631) 853-8333 (VOICE)  
(631) 853-5658 (TTY)  
(631) 853-8339 (FAX)**

COUNTY OF SUFFOLK



STEVE LEVY  
SUFFOLK COUNTY EXECUTIVE

OFFICE OF THE COUNTY EXECUTIVE

OFFICE OF HANDICAPPED SERVICES  
BRUCE G. BLOWER  
DIRECTOR

Dear Paratransit Applicant:

Enclosed is an application for the Suffolk County Accessible Transit (SCAT) Paratransit system. SCAT is for people whose disability is so severe that it prevents them from using public buses. It is not necessary for you to obtain a medical certification, but **please answer all the questions**. This will enable us to determine your eligibility. All information will be kept confidential.

When you have completed and signed the application, mail it and **two identical (or similar) black and white, or color passport size photographs** (no photocopies) to:

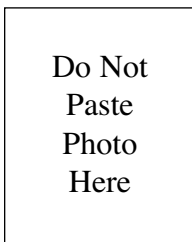
Suffolk County Office of Handicapped Services  
Building 158, North County Complex  
P.O. Box 6100  
Hauppauge, NY 11788-0099

You will be notified as to your eligibility by mail within three weeks.

The specifications for the two original photographs are: clear, full face, front view. Your face should fit in a 1" x 1 1/4" area, the size of the box below, just print your name on the back of each photo and attach them to the application.

On the other side of this cover letter is information about Paratransit. If you have any questions, or need assistance filling out the application, please feel free to call us at 853-8337 (voice), or if hearing impaired phone 853-5658 (TTY). Also, copies of the federal Department of Transportation and ADA Paratransit standards are available upon request.

Size of photo



Very truly yours,

Bruce G. Blower, Director  
Suffolk County Office of  
Handicapped Services

BGB:mk  
Enc.

**PLEASE SAVE THIS LETTER!**

**----> OVER**

## **SCAT-PARATRANSIT PROCEDURES AND GUIDELINES**

1. To make a trip reservation, call the Suffolk County Accessible Transit (SCAT) Paratransit dispatcher at 631.738.1150 (voice) or 631.981.0104 (TTY). **ALL RESERVATIONS ARE SUBJECT TO AVAILABILITY.** Riders are entitled to trips on a first-come, first-served basis.
2. Reservations may be made up to 7 days in advance and no later than one day prior to the day you want to ride, if available. Multiple reservations can be made at one time. Since reservations are on a first-come, first-served basis you may not always get the reservations you desire if those time slots have already been taken.
3. Reservations can be made between 8:00 am and 4:30 pm, Monday through Saturday. On Sundays, reservations can be made between 8:00 am and 4:30 pm, **for next day travel only.**
4. The first daily pick-ups begin as early as 6:00 am on Monday through Friday, (7:00 am on Saturday), and the last daily pick-up will be at about 8:30 pm and later in those areas where SCT bus lines continue to operate later in the evening. **Please note that since there is no bus service on Sundays or on holidays there is no Paratransit service on these days either.**
5. The fare is \$3.00 one way (\$6.00 round trip). **Exact fare is required.**
6. For riders requiring a personal care attendant (PCA), as shown on ID card, the attendant will travel free. In addition to the PCA, one companion can also accompany the rider by paying the full fare. Additional companions may also accompany the rider, but only if sufficient vehicle capacity can accommodate them and they each must also pay the full fare.
7. Riders must have their I.D. card with them when using SCAT identifying them as ADA Paratransit eligible. (If you do not yet have your ID card, bring your eligibility certification letter along on the trip).
8. If cancellation of your reservation is necessary, it must be made at least two (2) hours before your scheduled pick-up time. In an emergency, call as soon as possible. **However, riders who are repeat no shows or cancel excessively risk having their riding privileges suspended or revoked.**
9. Service is curb-to-curb only. Please do not ask driver for door-to-door service. You must be at the curb 15 minutes before your scheduled pick up. Drivers cannot leave the bus to bring riders to or from the curb.
10. All pick-up and drop-off locations must be within Suffolk County, NY. Trip origins and destinations must be within 3/4 of a mile of a Suffolk County Transit or HART (for trips within Huntington) fixed bus route.
11. Please note the SCAT bus has a half-hour window, where they can show up 15 minutes before or 15 minutes after your scheduled pick-up time. **YOU MUST BE READY DURING THIS ENTIRE WINDOW BECAUSE THE BUS WILL NOT WAIT MORE THAN 10 MINUTES FOR YOU.**
12. If you are able to use the public bus system for any trips, we urge you to do so, to make room for people who can only travel via Paratransit. Thank you for your cooperation.

**PLEASE RETAIN THIS COPY FOR YOUR RECORDS**

# SCAT PARATRANSIT APPLICATION FORM

## PART 1. GENERAL INFORMATION

M  F  DATE OF BIRTH:  /  /

LAST NAME  FIRST NAME  MI

STREET ADDRESS:  APT/BLDG #:

CITY:  COUNTY:  ZIP CODE:

HOME PHONE NUMBER ( ) - WORK PHONE NUMBER ( ) -

NEAREST CROSS STREET  EMAIL: \_\_\_\_\_

### MAILING ADDRESS: *If different from above*

STREET ADDRESS:  APT/BLDG #:

CITY:  COUNTY:  ZIP CODE:

### 1. Do you require information and material given to you in any of the following ways?

*Mark all that you need*

Braille  Large Print  Audio Tape  Other: \_\_\_\_\_

### PLEASE GIVE US THE NAME AND TELEPHONE NUMBER OF SOMEONE WE CAN CALL IN AN EMERGENCY.

LAST NAME  FIRST NAME

HOME PHONE NUMBER ( ) - WORK PHONE NUMBER ( ) -

DO NOT WRITE BELOW THIS LINE

CERTIFICATION DATA	
ID# _____	DATE RECEIVED _____
Date Issued: _____	
Expiration Date: _____	
Eligibility Category: _____	
Certifier: _____	
Comments: _____	

# SCAT PARATRANSIT APPLICATION FORM

## 2. Please indicate below if you use any of the following mobility aides or equipment.

- Cane
- Crutches
- Long white cane (for the visually impaired)
- Service/guide animal (describe) \_\_\_\_\_
- Walker
- Leg braces
- Manual wheelchair
- Powered wheelchair
- Powered scooter/cart
- Respirator/oxygen tank
- Other \_\_\_\_\_
- I don't require any assistive devices

*Note: We may not be able to accommodate the applicant if the wheelchair or scooter is longer than 48" or wider than 32 3/4", or if the combined weight of the applicant and wheelchair is more than 600 pounds.*

## **PART 2. QUESTIONS ABOUT USING FIXED BUSES**

### 3. Have you ever used the fixed route buses?

- Yes, I typically use fixed route buses \_\_\_\_\_ times a week.
- Yes, but only for trips I am familiar with.
- Yes, I used to but stopped because \_\_\_\_\_
- No

### 4. If you currently do not use the fixed route is there something that might help you to ride the buses? (Mark all that apply.)

- Yes, route and schedule information.
- Yes, buses with wheelchair lifts.
- Yes, learning to use the buses.
- Yes, a communication aid.
- Yes, if bus stops were closer to where I live and where I need to go.
- Yes, (describe): \_\_\_\_\_
- No, none of these would help.

### 5. How far from your home is the nearest bus stop?

- Less than 1 block
- 1-2 blocks
- 3-4 blocks
- 5 or more blocks
- I don't know

### 6. On your own or using an assistive device, how far can you travel?

- I can get to the curb in front of my house/apartment
- I can travel up to 3 blocks (1/4 mile)
- I can travel up to 6 blocks (1/2 mile)
- I can travel up to 9 blocks (3/4 mile)
- I don't know.

# SCAT PARATRANSIT APPLICATION FORM

**7. Please mark ALL the disabilities that prevent you the applicant from using the fixed route.**

<input type="checkbox"/> AIDS	<input type="checkbox"/> Kidney Disease/Dialysis
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Legally Blind
<input type="checkbox"/> Asthma	<input type="checkbox"/> Lupus
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Macular Degeneration
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Mental Retardation
<input type="checkbox"/> Autism	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Panic Disorder
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Paraplegia
<input type="checkbox"/> COPD	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Cortical Blindness	<input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Phobia
<input type="checkbox"/> Dementia	<input type="checkbox"/> Quadriplegic
<input type="checkbox"/> Diabetes (severe)	<input type="checkbox"/> Retinopathy
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Epilepsy (severe)	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Stroke/Cerebral Trauma
<input type="checkbox"/> Head Trauma	<input type="checkbox"/> Thrombosis (chronic)
	<input type="checkbox"/> Totally Blind

# SCAT PARATRANSIT APPLICATION FORM

8. How does your identified disability prevent you, the applicant from riding the fixed route buses? Please explain in **DETAIL**.

---

---

---

---

9. Is this condition permanent? YES NO

Is this condition temporary? YES NO

If temporary, what is the expected duration? \_\_\_\_\_  
(Number of months)

10. Does the applicant need to travel with their own Personal Care Attendant (PCA)?

- Yes
- No
- Sometimes

11. Is the applicant able to travel to and from a bus stop?

Yes No

**If no, please indicate all that apply:**

- Cannot negotiate where there are no sidewalks.
- Cannot travel if there are no curb cuts.
- Cannot cross busy streets and intersections.
- Cannot tolerate extreme temperatures.
- Cannot travel on surfaces covered with ice/snow.
- Cannot locate or identify bus stop due to a visual impairment.
- Easily becomes confused and may get lost.
- Other (please specify): \_\_\_\_\_

# SCAT PARATRANSIT APPLICATION FORM

**12. Is the applicant able to perform the following functions without assistance from another person?**

	YES	NO
Find his/her way between familiar locations?	<input type="checkbox"/>	<input type="checkbox"/>
Grasp coins, passes, railings, and handles?	<input type="checkbox"/>	<input type="checkbox"/>
Climb up and down three 12 inch steps?	<input type="checkbox"/>	<input type="checkbox"/>
Travel 3/4 mile to a bus stop?	<input type="checkbox"/>	<input type="checkbox"/>
Identify the stop at your destination?	<input type="checkbox"/>	<input type="checkbox"/>
Deal with unexpected situations or unexpected changes in routine?	<input type="checkbox"/>	<input type="checkbox"/>

Please list the names of two professionals, (physicians, agencies, or others familiar with your disability), whom we may contact if verification of information is required:

Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State:   Zip Code:       -

Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State:   Zip Code:       -

COMMENTS:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# SCAT PARATRANSIT APPLICATION FORM

## Release and Certification of Information:

I, the applicant, understand that the purpose of this application form is to determine my eligibility to use the SCAT System. I agree to release the information requested to SCAT and any eligibility review panel and understand that the information contained herein will be treated confidentially. I understand that SCAT reserves the right to request additional information at its discretion.

I hereby certify that **ALL** information provided by me on this application is TRUE and ACCURATE.

**ANY FALSE STATEMENTS MADE HEREIN ARE PUNISHABLE  
PURSUANT TO PENAL LAW 210.45 OF THE STATE OF NEW YORK.**

---

Signature of applicant

Date

---

Printed name of applicant

---

Signature of preparer (if other than applicant)

Date

---

Printed name of preparer, relationship or agency name

---

This application form must be completed and sent, together with 1" x 1 1/4" identification-type photos as described in the cover letter to:

SCAT  
c/o Suffolk County Office of Handicapped Services  
Bldg. 158, North County Complex  
P.O. Box 6100  
Hauppauge, NY 11788-0099  
(631) 853-8333 (VOICE)  
(631) 853-5658 (TTY)