**TOWN OF SMITHTOWN**
**OFFICE FOR PEOPLE WITH DISABILITIES**
**420 MIDDLE COUNTRY ROAD**
**SMITHTOWN, NEW YORK 11787**
**PHONE: 360-7642 FAX: 360-7689**
handicappedservices@tosgov.com www.smithtownny.gov

# HANDI-VAN ENROLLMENT APPLICATION

## PART 1 (To be completed by the Applicant) Page 1 of 2

| | | |
|---|---|---|
| Applicant's Last Name | First Name | M.I. |
| Address of Applicant's Residence | | |
| Phone Number (Day) | Phone Number (Cell ) | Date of Birth |
| Who should be contacted in case of Emergency? | | |
| Phone Number (Day) | Phone Number (Cell) | Relationship to Applicant |
| Mailing Address of Emergency Contact: | | |
| **Only complete this section to designate another person ("Third Party") to be contacted regarding this program and the applicant's use of it.** | | |
| Name of 'Third Party' Contact | | |
| Phone Number (Day) | Phone Number (Cell) | Relationship to Applicant |
| Mailing Address of Third Party Contact | | |
| Should this designated individual be contacted INSTEAD of the applicant? | If "Yes", briefly explain why: | |

**FOR OFFICE FOR PEOPLE WITH DISABILITIES USE ONLY:**

Enrollment Date: _____ Re-Certification Date: _____

## PART 1 (continued) Page 2 of 2

**MOBILITY AIDS** ☐ ----- Check the mobility aids you travel with:

☐ Cane ☐ Wheelchair* (Manual) ☐ Service Animal

☐ Walker ☐ Wheelchair* (Electric) ☐ Other:

☐ Braces ☐ Powered Scooter*

*If you use a wheelchair or a scooter, can you transfer to a seat?

☐ No ☐ Yes

Do you require the use of a bus lift?

☐ Yes ☐ No

If your answer was "Yes," does the combined weight of you and the mobility aid exceed eight hundred (800) pounds?
**Please note that the Handi-Van lift can accommodate weight up to eight hundred (800) pounds.**

☐ Yes ☐ No

**PERSONAL TRAVEL ASSISTANCE**

Do you at least sometimes require the assistance of a personal care attendant (family member, friend, aide, etc.) in order to access/use the Handi-Van or to help you at you at your destination?
If you checked "Yes," explain what help you might need from another person in order to access/use the Handi-Van or at your destination.

☐ Yes ☐ No

_____

_____

**CERTIFICATION MUST BE ENDORSED BY APPLICANT OR AUTHORIZED SIGNATORY**

I, the undersigned applicant (or authorized signatory thereof), do hereby state that the information contained herein is true and complete. **I am aware that the Town of Smithtown Handi-Van provides only minimal ambulatory assistance.** In the event that my condition changes such that recertification by the Town of Smithtown Office for People with Disabilities is necessary, I understand and agree to fully cooperate with the Town of Smithtown Office for People with Disabilities in obtaining any and all medical information required from my physician regarding my medical diagnosis and/or treatment as well as any disability restrictions. This includes the completion and signing of any and all forms necessary for the release of medical records from my physician regarding my medical diagnosis and/or treatment as well as any disability restrictions. I understand that all information will be held in strict confidence and will be used solely to enable the Town of Smithtown Office for People with Disabilities.

| Signature | Date |
|---|---|
| | |

**Remember to sign the Certification and have a health care professional complete PART 2.**

**TOWN OF SMITHTOWN**
**OFFICE FOR PEOPLE WITH DISABILITIES**

# HANDI-VAN ENROLLMENT APPLICATION

## PART 2 (Professional Verification of Disability) Page 1 of 2

Your patient is applying to use the Town of Smithtown Handicapped Accessible Transportation on the basis that he/she is disabled. This form is to be completed by a health care professional who is familiar with the applicant, his/her disability, and his/her functional abilities. The information you provide will allow the Town of Smithtown to make an appropriate evaluation of this application and specific trip requests. Please fully answer all questions that apply to this applicant since an incomplete application will delay the enrollment process.

If you are submitting this form directly on behalf of the applicant, please mail to**: Town of Smithtown, Office for People with Disabilities, 65 Maple Ave, Smithtown, NY 11787. If you need additional information, please telephone (631) 360-7642 or fax (631) 360-7640.**

| Applicant's Name | Applicant's Address |
|---|---|
| | |

MEDICAL CONDITION----What is the specific disability or impairment-related condition?

_____

Is this condition temporary?

No ☐ Yes ☐ If "Yes", expected duration until: _____

| | | | |
|---|---|---|---|
| Can the applicant climb three 12-inch steps without the assistance of another person? | Yes ☐ | No ☐ | Sometimes |
| Can the applicant wait outside without support for ten minutes? | Yes ☐ | No ☐ | Sometimes |
| Can the applicant get in and out of his/her home without the assistance of another person? | Yes ☐ | No ☐ | Sometimes |
| Can the applicant get to and from the curb or pavement edge without the assistance of another person? | Yes ☐ | No ☐ | Sometimes |
| Can the applicant be transported safely in a seated position? | Yes ☐ | No ☐ | Sometimes |

## PART 2 (Professional Verification of Disability) Page 2 of 2

| | |
|---|---|
| Please indicate what, if any, mobility aids are used by the applicant: | Does the applicant **require** the assistance of a personal care attendant in order to access/use the Handi-Van, or to help the applicant at his/her destination? ☐ Yes ☐ No |
| Are you aware of any behavioral abnormalities exhibited by the applicant that could cause him/her to possibly harm him/herself, other passengers, or the bus driver? ☐ Yes ☐ No<br>If "Yes," please explain: | Is there any other effect of the disability of which Office for People with Disabilities should by aware? ☐ Yes ☐ No<br>If "Yes," please explain: |

If the applicant has a cognitive disability, is he/she able to:

| | | |
|---|---|---|
| Give addresses and phone numbers upon request? | Y | N |
| Recognize a destination or landmark? | Y | N |
| Deal with unexpected situations or unexpected change in routine? | Y | N |
| Ask for, understand, and follow directions? | Y | N |
| Safely and effectively travel through crowded and/or complex facilities? | Y | N |

IF the applicant has a visual impairment:

| Visual acuity with best correction | | Visual fields | |
|---|---|---|---|
| Left Eye | | Left Eye | |
| Right Eye | | Right Eye | |
| Both Eyes | | Both Eyes | |

I also certify that the medical information provided in the application is accurate to the best of my knowledge and is consistent with the applicant's medical diagnosis.

Signed this _____day of _____, 20____

_____
(Name of Physician)

Please place Medical office stamp here

_____
(Signature of Physician)

_____
(License Number)

_____
(Phone Number)

_____
(City) (State) (Zip)

PLEASE NOTE: ONLY THE ORIGINAL FORMS OF THIS DOCUMENT WILL BE ACCEPTED.