OFFICE OF THE SUFFOLK COUNTY EXECUTIVE
OFFICE FOR PEOPLE WITH DISABILITIES
BLDG.158, WILLIAM J LINDSDAY COUNTY COMPLEX
P.O. BOX 6100
HAUPPAUGE, NY 11788-0099

SCAT/PARATRANSIT APPLICATION

ED ROMAINE
SUFFOLK COUNTY
EXECUTIVE
FRANK KROTSCHINSKY ESQ.,
DIRECTOR OFFICE FOR PEOPLE
WITH DISABILITIES
WILLIAM J LINDSAY COUNTY
COMPLEX, BLDG 158
725 VETERANS MEMORIAL HWY.
P.O. BOX 6100
HAUPPAUGE, NY 11788-0099

(631) 853-8333 (VOICE)
(631) 853-5658 (TTY)
(631) 853-8339 (FAX)

WWW.SUFFOLKCOUNTYNY.GOV

11/2023 D-WS

SCAT PARATRANSIT APPLICATION FORM

SCAT PARATRANSIT OVERVIEW

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. In compliance with the Americans with Disabilities Act of 1990 (ADA) Suffolk County provides curb-to-curb paratransit services for the SCAT Program to anyone who, because of physical or mental disability, is unable to use the regular, fixed route bus service. Age, distance from a bus stop, or inability to drive, are conditions which are not taken into consideration in making an eligibility determination.

This application form is intended to determine the circumstances under which the applicant can use the regular, fixed route bus system. Each application will be evaluated on a case-by-case basis, taking into consideration all of the information provided. As part of the eligibility process, you may be required to undergo an in-depth interview. Failure to attend will result in denial of your application.

The applicant, or someone assisting them, must complete all the questions. **A New York State licensed medical professional is required to complete the medical certification, this consists only of an M.D., D.O., P.A., N.P, or D.C. ONLY**
If you do not have access to a licensed medical professional, please call (631) 853-8333 for assistance.

When you have completed and signed the application, mail it **(original only, we will not accept photocopies or faxes of this application) to:**

Suffolk County Office for People with Disabilities
William J. Lindsay County Complex, Building 158
725 Veterans Memorial Hwy.
P.O. Box 6100
Hauppauge, NY 11788-0099

You will be notified as to your eligibility by mail within 21 business days.

As of Sept. 30, 2022, The Office for People with Disabilities will no longer be issuing SCAT ID cards. Riders can use a Government issued photo identification card or a University identification card instead.

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 (631) 853-8333 (voice), or if hearing impaired phone (631) 853-5658 (TTY).

Revised scat-paratransit procedures & guidelines 10/29/23

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 5 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 reservation you desire if those time slots have already been taken.

3) Reservations can be made between 7:00 a.m. and 5:00 p.m., Monday through Saturday. On Sundays, reservations can be made between 8:00 a.m. and 4:30 p.m. When you call to make a reservation, you must give the reservationist the complete address of where you are going.

4) The first daily pick-up will be 5:00 a.m. Monday through Saturday (6:00 a.m. on Sunday), and the last daily pick-up will be 10:00 p.m. for Monday through Saturday and (8:00 p.m. on Sunday). It will be 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 certain holidays, there will be no Paratransit service on those days either so please check with SCAT before you plan your trip.**

5) The fare is $4.00 one way ($8.00 round trip). **Exact fare is required.**

6) For riders requiring a personal care attendant (PCA), 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 but they must also pay the full fare.

7) The Office for People with Disabilities will no longer be issuing SCAT ID cards. **Riders can use a Government issued Photo Identification card or a University Identification card instead.**

8) If you need to cancel your reservation, please do so as soon as possible, but 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. SCAT may also approve limited assistance between curbside and a building's entrance along an accessible path when requested at the time trip reservations are made, in accordance with the Origin to Destination Policy.

10) Drivers are not required to carry packages for you. Maximum number of packages passengers are permitted to bring on a single boarding is determined on what they can safely carry on and off the vehicle. While on board the vehicle, packages must be stored in a location that does not block path of travel within the vehicle, or interfere with safety features, or securement of other passengers.

11) All pick-up and drop-off locations must be within Suffolk County, NY. Service is no longer limited to be within ¾ of a mile of a Suffolk County Transit route. Trips that begin and end in Town of Huntington are handled by the HART paratransit system. There is no service on Shelter Island.

12) Please note the SCAT bus has a half-hour window, where it 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.**

13) If you are able to use the public bus system for some of your trips, we urge you to do so. It is less expensive for you and makes room for people who can only travel via Paratransit. Thank you for your cooperation.

P L E A S E S A V E!

SCAT PARATRANSIT APPLICATION FORM

☐ First time applying or

☐ Recertifying SCAT ID#_____

Please print only and complete with a pen.

_____
(Date of Birth)

_____
(Last Name) (First Name) (MI)

_____
(Street Address) (Apt/Bldg.)

_____
(City) (County) (Zip Code)

Home phone: _____ Cell number: _____

Email: _____

Mailing address: ***(If different from above)***

_____
(Street address) (Apt/Bldg.)

_____
(City) (County) (Zip Code)

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

☐ Braille ☐ large print ☐ audio format ☐ language _____ ☐ other _____

Please give us the name and telephone number of someone we can call in an Emergency.

_____
(Last Name) (First Name)

_____
(Cell number) (Alternate number)

Please do not write below this line

CERTIFICATION_DATA

(Certifier initials) **(Date received)**

PLEASE NOTE: ONLY ORIGINAL FORMS OF THIS DOCUMENT WILL BE ACCEPTED **Revised 3/1/23 D-WS**

SCAT PARATRANSIT APPLICATION FORM

1) 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.

2) 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

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

4) How far from your home is the nearest bus stop?

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

5) 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

6) Please mark ALL of the disabilities that prevent you the applicant from using the fixed route.

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

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

_____

_____

_____

8) Is this condition permanent? ❑ YES ❑ NO

Is this condition temporary? ❑ YES ❑ NO

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

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

A companion that travels with an applicant must pay the full fare.

❑ YES ❑ NO

10) 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): _____

11) Is the applicant able to perform the following functions without assistance from another person?

	YES	NO
Find their way between familiar locations?	☐	☐
Grasp coins, passes, railings and handles?	☐	☐
Climb up and down three 12 inch steps?	☐	☐
Travel 3/4 miles to a bus stop?	☐	☐
Identify the stop at your destination?	☐	☐
Deal with unexpected situations or unexpected changes in routine	☐	☐

12) Do you use any other type of transportation service? (Please check the appropriate box)

☐ Medicaid Transportation

☐ Senior Transportation

☐ Other (Please explain) _____

Dear Health Care Professional (M.D., D.O., P.A., N.P., or D.C. **ONLY**):

You are being asked to provide information regarding this applicant's disability. The Federal Law is very specific about ADA Paratransit eligibility. The law restricts eligibility to individuals who:

1. As a result of their disability, cannot board, ride, or disembark from a regular bus or

2. Have a specific impairment-related condition that prevents them from getting to or from a bus stop.

3. Need a wheelchair lift when a wheelchair lift-equipped bus is not available on the route that they need to travel.

PLEASE NOTE: This does not include persons who find it difficult or uncomfortable to get to and from bus stops. In providing the information, you should consider only the presence of a disability or health condition and not the applicant's age or economic status.

This application is intended to determine whether the applicant can use regular transit service (fixed route) or whether he/she requires curb-to-curb service. Please exercise care in evaluating applicants. Your evaluation must be based solely upon the applicant's ability to use regular transit. Carefully evaluating these criteria will ensure that reliable Paratransit service is available for those who truly require it. This form must be completed in its entirety; any question left blank will deem this form void and incomplete.

IF THE APPLICANT COMPLETES THIS FORM, IT WILL BE DEEMED VOID.

Please write clearly and legibly

Please mark all the disabilities, which prevent the applicant from using the fixed route bus service. Conditions, which make it difficult or uncomfortable, should not be checked.

The health care professional completing this application certifies that _____, is a severely disabled person whose functional limitation is: (Name of applicant)

1) Neuromuscular

- ❑ Amputation of (specify)_____
- ❑ Cerebral Palsy
- ❑ Muscular Dystrophy
- ❑ Parkinson's Disease
- ❑ Spina Bifida
- ❑ Stroke

2) Cardiovascular

- ❑ Arteriosclerosis
- ❑ Asthma
- ❑ Cystic Fibrosis
- ❑ Heart Attack
- ❑ Emphysema
- ❑ Congestive Heart Failure

(continued……)

1) Neuromuscular

❑ Brain Injury
❑ Quadriplegia
❑ Multiple Sclerosis
❑ Paraplegia
❑ Polio
❑ Arthritis
❑ Other: _____
❑ None

2) Cardiovascular

❑ COPD
❑ Peripheral Vascular Disease
❑ Thrombosis (Chronic)
❑ Other:_____
❑ None

3) Vision *(mark all that apply)*

	One Eye	Both Eyes
Cataracts	❑	❑
Glaucoma	❑	❑
Macular Degeneration	❑	❑
Retinal Detachment	❑	❑
Retinopathy	❑	❑
Totally Blind	❑	❑
Legally Blind	❑	❑

Other:_____
❑ None

4) General Medical

❑ AIDS
❑ Diabetes (severe)
❑ Cancer
❑ Lupus
❑ Epilepsy (severe)
❑ Kidney Disease/Dialysis
❑ Other:_____
❑ None

5) <u>Cognitive/Psychological</u>

- ❑ Alzheimer's Disease
- ❑ Autism
- ❑ Dementia
- ❑ Head Trauma
- ❑ Cognitive Impairment
- ❑ Schizophrenia
- ❑ Anxiety
- ❑ Depression
- ❑ Panic Attacks
- ❑ None

(5a) Do the above conditions respond to medication? _____ Yes _____ No

(5b) For anxiety/panic attacks please indicate on average the frequency and length of the attacks.

_____ per day_____ per week _____ per month _____ per year _____ approx. duration

6) What disability prevents the applicant from riding the regular bus system? A detailed diagnosis is required. Please be specific. (Please do not use diagnostic codes).

_____

_____

7) How does their disability affect the applicant's functional ability and prevent them from riding the regular bus system? (Please explain in detail):_____

_____

8) Is this condition: ☐ Permanent ☐ Temporary (If temporary, what is the expected duration?) _____(number of months)

9) Does the applicant's disability require that they travel with an attendant? _____Yes _____No

10) Is the applicant able to travel to and from a bus stop? _____Yes _____No

10a) If no, please indicate all that apply:

- ❑ Cannot negotiate if the street or sidewalk is too steep.
- ❑ Cannot travel if there are no sub cuts.
- ❑ Cannot cross busy streets and intersections.
- ❑ Cannot locate bus stop due to a visual impairment.
- ❑ Cannot wait outside without support for 15 minutes.
- ❑ Easily becomes confused and may get lost.
- ❑ Other (please specify)_____

11) Please, specify the applicant's ability to independently perform the following functions using the most effective mobility aid.

	Little or No Difficulty	Discomfort and/or some Difficulty	Severe pain or impairment	Impossible or likely to cause a serious medical crisis
Find their way between Familiar locations	☐	☐	☐	☐
Handle money or tickets	☐	☐	☐	☐
Give address and telephone Number upon request	☐	☐	☐	☐
Recognize a destination or landmark	☐	☐	☐	☐
Ask for and understand directions	☐	☐	☐	☐
Travel 200 ft. (city block)	☐	☐	☐	☐
Travel ¼ mile (three blocks)	☐	☐	☐	☐
Deal with unexpected situations or unexpected changes in routine	☐	☐	☐	☐
Safely and effectively travel through crowded facilities	☐	☐	☐	☐

SCAT APPLICATION MEDICAL FORM

Applications with illegible or incomplete information will be returned and deemed void.

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)

_____
(Street address)

_____
(City) (State) (Zip)

APPLICANT'S CERTIFICATION, CONSENT OR RELEASE OF APPLICATION 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. By signing, I authorize the licensed medical professional who signed this application to use and/or disclose certain protected health (PHI) about me to Suffolk County Office for People with Disabilities. The information will be used or disclosed for the following purpose: To determine eligibility to use the SCAT paratransit service.

I understand that my application **will be returned if it is not complete**. I confirm that all the information that I provide on this application is true to the best of my knowledge. I understand that my application is subject to review and verification and that misrepresentation of any material information will lead to the revocation of my certification. I understand that a false statement made herein may result in the rejection of my application for paratransit service.

I understand the application process can take up to 21 days from the time SCAT receives a completed application. If my application is returned for clarification or additional information, this can delay the process.

I agree to notify Suffolk County Office for People with Disabilities at (631) 853-8333 if I no longer need Paratransit for any reason, including a change in my ability to use bus service. I also understand that failure to adhere to the policies and procedures for using Paratransit may be grounds for suspending or revoking my eligibility to participate in this program.

In the event that I apply for Paratransit eligibility in another community, I hereby authorize SCAT Paratransit to release the information on my SCAT application to such agency.

CERTFICATION: The information I have given on this application is true to the best of my knowledge. **False statements are punishable under Section 210.45 of the Penal Law.**

_____

Signature of Applicant | Printed Name of Applicant | Date

_____

Signature of preparer | Printed Name of Preparer | Date

_____

(If other than applicant, Doctor or Staff that have assisted), Relationship, Agency name and Phone No.)

This application form must be completed and mailed to: SCAT

c/o Suffolk County Office for People with Disabilities
Williams J. Lindsay County Complex, Bldg.158
725 Veterans Memorial Hwy., P.O. Box 6100
Hauppauge, NY 11788-0099
(631) 853-8333 (VOICE)
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