What is the Individual Access Pass?

The Individual Access Pass permits a resident of New York State with a disability, as defined in the attached application, free or discounted use of parks, historic sites, and recreational facilities operated by the New York State Office of Parks, Recreation and Historic Preservation and the New York State Department of Environmental Conservation. For a description of these facilities, visit **www.parks.ny.gov** and **www.dec.ny.gov**.

The pass holder may have free or discounted use of facilities operated by these offices, for which there is normally a charge — for example, parking, camping, greens fees, swimming.

The Individual Access Pass is not valid for waiver of fees such as those for seasonal marina dockage, group camp or cottage rental, performing arts programs, consumables (i.e. firewood, electric, or gas), campsite/cabin amenities, reservations and registrations, as well as some services or locations operated by an outside concessionaire.

Access Pass qualifications and requirements are described within the application.

The Access Pass includes an expiration date. It is the responsibility of the pass holder to reapply in order to obtain a new pass. There is no renewal process.

The Office of Parks, Recreation and Historic Preservation is authorized to collect this information by Section 3.09 of the Parks, Recreation and Historic Preservation Law. It will be used to determine your eligibility and to process your application. If the information you provide is not complete, it will not be possible to process your application. The information will be maintained by the Regional Programs and Services Bureau, State Parks, Albany, NY 12238, **518-474-2324**, TTY/TDD through 711 Relay Service. The information may also be used to contact you about this and other programs of the New York State Office of Parks, Recreation and Historic Preservation.

To ensure that your application can be approved for processing, please be sure that all of the items below are included when submitting your application.

PART 1

- Completed all the Applicant Information. (**Part A**)
- Include a copy of the applicant's NYS Driver's License, Non-Driver ID card, or interim ID card. (**Part B**)
- Sign and Date the Authorization and Certification. (**Part C**)

PART 2

- Based on your disability, applicant must complete Part A **OR** be sure to have your physician complete Part B with Signature/Date/Physician's Stamp
- This application **cannot** be processed on site at any location.

Email this application, enclosing all required materials to:

Accesspass@parks.ny.gov

Or mail to:

Access Pass
New York State Parks
Albany, NY 12238

Please allow 2 - 4 weeks for processing of this application

Contact Us

For questions, email us at **Accesspass@parks.ny.gov** or visit our Contact Us page at **parks.ny.gov/admission**.

ACCESS PASS
NEW YORK STATE PARKS
ALBANY, NEW YORK 12238

Printed on Recycled Paper

INDIVIDUAL ACCESS PASS

APPLICATION

NEW YORK STATE | Parks, Recreation and Historic Preservation | Department of Environmental Conservation

parks.ny.gov | dec.ny.gov

Individual Access Pass Guidelines

An Equal Opportunity/Affirmative Action Agency Program

RS 8 10/23

INCOMPLETE ACCESS PASS APPLICATIONS WILL BE RETURNED

PART ONE: Personal Information

Applicant must complete **Sections A - C**

A. APPLICANT INFORMATION

OFFICE USE ONLY

Disability Code _____ Denial Code (s) _____

Approved By _____ Denied By _____

Birth Date

Last 4 of Social Security No. XXXX XX

First Name

Last Name

Street Address

Mailing Address (if different from street address)

City or Town | State NY | Zip Code

City or Town | State NY | Zip Code

Telephone Number

Email Address *(if you would like to receive NY State Parks program information.)*

Preferred Contact ◯ email ◯ phone

B. RESIDENCY REQUIREMENT

Applicant must provide a copy of one of the following which must be in the name of the applicant.

A copy of a currently valid New York State Driver License, Non-Driver ID card or interim ID card. Scan the QR code to learn how to apply.

C. AUTHORIZATION & CERTIFICATION

I authorize the release of any pertinent medical information needed to process this application. I certify that the information provided is true to the best of my knowledge and believe and understand that any person who knowingly files a statement containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act. **ANY FALSE STATEMENT MADE HEREIN IS PUNISHABLE AS A CLASS "A" MISDEMEANOR PURSUANT TO SECTION 210.45 OF THE PENAL LAW.**

_____ *Applicant/Parent/Legal Guardian Signature*

_____ *Date*

Parent or Legal Guardian must sign for applicants under 18 years of age

PART TWO: Certification

Applicant must complete **Section A**
OR Physician must complete **Section B**

All certification must be dated within ONE YEAR of this application's date. PLEASE NOTE:

The following are **NOT** acceptable proofs of disability or certification:

- New York State Handicapped Parking Permit
- Medicare or Medicaid Card
- Social Security Statement
- New York State Employees Retirement System
- New York State Workers Compensation Board
- Insurance Company

A. ORGANIZATION CERTIFICATION:

Attach certification of one of the following issued within **ONE YEAR** of this application's date:

◯ **BL** Person who is blind: Certification from the New York State Commission for the Blind that the applicant is legally blind, defined as: when a person's visual acuity is 20/200 or less in the better eye with best correction, or their field of vision is 20 degrees or less in the better eye.

◯ **DD** Person who has a developmental disability: Certification from the New York State Office for People With Developmental Disabilities that the applicant is eligible to receive services from a program they license, operate, certify, or fund. Common forms of certification are a Level of Care Eligibility Determination (LCED), OR Lifeplan, OR Home and Community Based Services Waiver (HCBS).

◯ **MH** Person who has a mental disability: Certification from the New York State Office of Mental Health that the applicant is receiving services from a program they license, operate, certify, OR fund.

B. PHYSICIAN CERTIFICATION:

To be completed by the physician for the disabilities below. **Physician must select** the applicable statement(s) and complete certification below within one year of the application date. A disabling condition is acceptable only if it causes one of the functional limitations listed below.
**Handwriting other or additional conditions will not be accepted.*

◯ **AM** Person who has an amputated arm or leg: has a fully or partially amputated or congenitally absent arm or leg, excluding the extremities of the hands (fingers) and feet (toes).

◯ **BL** Person who is blind: has a central visual acuity of 20/200 or less or limitation in the field of vision such that the widest diameter of the visual field subtends an angle no greater than twenty degrees in the better eye with the use of a correcting lens.

◯ **DF** Person who is deaf: has profound hearing loss causing the person to primarily rely on visual communications (sign language, lip reading, gestures) and assistive technology.

◯ **WC** Person who is non-ambulatory: has a permanent disability which prevents them from being able to walk and therefore requires the use of a wheelchair at all times.

Physician **MUST** stamp the bottom of the application or provide a letter on provider letterhead explicitly stating one of the listed eligibility requirements in Part Two, Section B.

PHYSICIAN'S INFORMATION

First Name

Last Name

Suffix

Mailing Address

City or Town | State NY | Zip Code

Telephone Number

License Number

I certify the following: the applicant is disabled as indicated by my selection of the applicable qualification; I am currently licensed and practicing in New York State; the above information is true to the best of my knowledge; I believe and understand that any person who knowingly files a statement containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act.

ANY FALSE STATEMENT MADE HEREIN IS PUNISHABLE AS A CLASS "A" MISDEMEANOR PURSUANT TO SECTION 210.45 OF THE PENAL LAW.

_____ *Physician's Signature*

_____ *Date*

Physician's Stamp