Group Access Pass

A Group Access Pass permits residents of New York State with a permanent disability, as defined in the application, free 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.nysparks.com and www.dec.ny.gov.

The members of the group 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 Group Access Pass, however, is not valid at any facility within a park operated by a private concern under contract to the State, or for a waiver of fees such as those for seasonal marina dockage, group camp rental, picnic shelter reservations, performing arts programs, consumables (i.e., firewood, electric, or gas), campsite/cabin amenities or fees related to campsite/cabin and marina reservations, registrations and refunding processing.

To qualify for a Group Access Pass, all members of the group must be residents of New York State. The group's authorized representative must provide proof of the group members' disability(ies) in the form of certification from the appropriate agency or by verification of disability (ies) by a physician AS DESCRIBED ON THE ATTACHED APPLICATION.

The authorized representative must complete parts one and two of this application, enclosing all required materials, and mail to:

Access Pass
State Parks
Albany, NY 12238

Please allow 8-10 weeks for processing of this application.

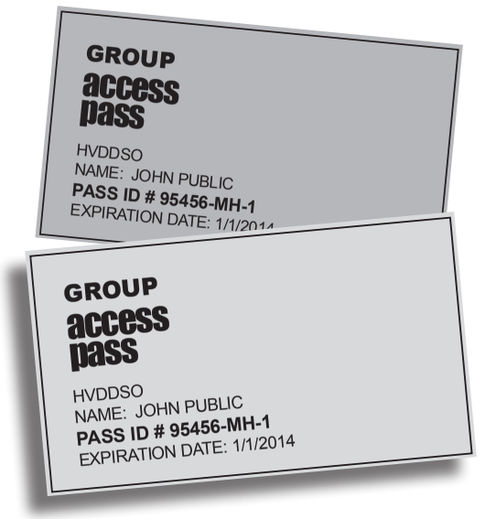
The Office of Parks, Recreation and Historic Preservation is authorized to collect this information by Section 3.09 of the Parks, Recreation and Historic Preservation Law. It will be used to determine your eligibility and to process your application. If the information you provide is not complete, it 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, TDD 518-486-1899. 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.

Access Pass
State Parks
Albany, New York 12238

OFFICE OF PARKS · RECREATION · HISTORIC PRESERVATION · NEW YORK STATE

GROUP

ACCESS PASS
APPLICATION



Printed on recycled paper

State of New York
www.state.ny.us

Office of Parks, Recreation & Historic Preservation
www.nysparks.com

Department of Environmental Conservation
www.dec.ny.gov

An Equal Opportunity/Affirmative Action Agency Program

RS 8 5/10

PART ONE: Group Information

Authorized Representative

First Name

Last Name

Group Name

Street Address

City or Town | State **NY** | Zip Code

Telephone Number

Area Code

QUANTITY OF PASSES (Passes are not assigned to specific vehicles , but each vehicle that is part of a group, including staff vehicles, must present a pass upon entering the facility.

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.

Authorized Representative's Signature _____

Date _____

PART TWO: Certification

AUTHORIZED REPRESENTATIVE MUST COMPLETE SECTION A *OR* PHYSICIAN MUST COMPLETE SECTION B.

A. ORGANIZATION CERTIFICATION: Attach certification of one of the following issued within one year of this application's date.

• **(BL)** Certification from the New York State Commission for the Blind and Visually Handicapped that group members have 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 to an angle no greater than 20° in the better eye with the use of a correction lens

• **(DD)** Certification that group members receive services licensed, operated, certified or funded by the New York State Office of Mental Retardation and Developmental Disabilities

• **(MH)** Certification that group members receive services licensed, operated, certified or funded by the New York State Office of Mental Health

• **(VA)** Certification from the United States Veterans Administration or the New York State Division of Veterans Affairs that group members are veterans of the wars of the United States with 40% or greater service connected disability or that they are eligible for or have been awarded by the federal government an allowance towards the purchase of an automobile

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The following are not acceptable proofs of disability:

• New York State Handicapped Parking permit
• Medicare or Medicaid card
• Veterans Administration medical treatment card

Disability certification from:

• New York State Employees Retirement System
• New York State Workers Compensation Board
• Insurance Company

B. PHYSICIAN CERTIFICATION: To be completed by the physician only if the Organization Certification in Section A is not provided. **Physician must initial or stamp** next to the applicable statement and complete certification below within 6 months of the application date. A disabling condition is acceptable only if it causes one of the functional limitations listed below.

____ **(AM)** has a fully or partially amputated or congenitally absent arm or leg, **excluding** the extremities of the hands (fingers) and feet (toes)

____ **(BL)** has 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 to an angle no greater than 20° in the better eye with the use of a correction lens

____ **(DF)** has a profound hearing loss causing the person to primarily rely on visual communications (sign language, lip reading, gestures) and assistive technology

____ **(DD)** receives services from a program licensed, operated, certified or funded by the New York State Office of Mental Retardation and Developmental Disabilities

____ **(MH)** receives services from a program licensed, operated, certified or funded by the New York State Office of Mental Health

____ **(WC)** is permanently disabled, requires use of a wheelchair **and** has severely limited mobility

Last Name | SUFFIX | First Name

Street Address | Telephone Number

City or Town | State **NY** | Zip Code | License Number

I certify that all group members, now or in the future, based upon the group membership criteria, are PERMANENTLY DISABLED as indicated by my initial or stamp next to the above qualification. I certify that I am currently licensed to and practicing in the State of New York and that the above information 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.

Physician's Signature _____ Date _____

Physician's Stamp