What is the Group Access Pass?

A Group Access Pass permits residents of New York State with disabilities, 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.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 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, for a group camp, for reservations of a picnic shelter, for performing arts programs, for consumables (i.e., firewood, electric, or gas), campsite/cabin amenities, or fees related to campsite/cabin reservations and registrations.

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.

√ Completed all the Applicant Information in Part One

√ Signed and dated the Authorization and Certification

√ Enclosed the proper organization certification

OR

Your physician completed all the information in Part Two, Section B

•This application **cannot** be processed on site at any location.

Mail or fax this application, enclosing all required materials to:

Access Pass
New York State Parks
Albany, NY 12238

FAX: 518-486-7378
ATTN: Access Pass

Please allow 2 - 4 weeks for processing of this application

For questions contact our office during regular business hours.
518-474-2324

TTY/TDD through 711 Relay Service

Printed on recycled paper

An Equal Opportunity/Affirmative Action Agency Program

RS 8 3/13

INCOMPLETE APPLICATIONS WILL BE RETURNED

PART ONE: Group Information *APPLICANT MUST COMPLETE SECTIONS A THROUGH C*

Office Use Only

Disability Code ______ *Certification Verification:*

Approved By ______ 1 2 3 4 5

Denial Code (s) _____

Denied By ______ *Notes:*

A. APPLICANT INFORMATION

Authorized Representative First Name

Authorized Representative Last Name

Group Name *(to be printed on Access Pass)*

City or Town State Zip Code

NY

Telephone Number

Email Address *(optional)*: ________________________

B. QUANTITY OF PASSES

Passes are not assigned to specific vehicles, but each vehicle that is a part of a group, including staff vehicles, must present a pass upon entering the facility. Please indicate the number of passes needed ________

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.**

Authorized Representative's Signature *Date*

PART TWO: Certification *APPLICANT 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** *Person who is blind:* Certification from the New York State Commission for the Blind and Visually Handicapped that the applicant 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.
- **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.
- **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.
- **VA** *Veteran who has a disability:* Certification from the United States Veterans Administration or the New York State Division of Veterans Affairs that the applicant is a veteran of the wars of the United States with a 40% or greater service connected disability as certified by the United States Veterans Administration, or who has at any time been awarded by the Federal government an allowance towards the purchase of an automobile or who is eligible for such an award.

B. PHYSICIAN CERTIFICATION:

To be completed by the physician only if the Organization Certification in Section A is not provided. ***Physician must select*** the applicable statement(s) 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** *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'S INFORMATION

First Name Last Name SUFFIX

Street Address Telephone Number

City or Town State Zip Code License Number

NY

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:**