Individual Access Pass

An Access Pass permits a resident of New York State with a permanent disability, as defined in the attached 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 passholder may have free use of facilities operated by these offices, for which there is normally a charge — for example, parking, camping, greens fees, swimming.

The 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, for a group camp, for reservations of a picnic shelter, for performing arts programs, for consumables (i.e., firewood, electric, or gas), for campsite/cabin amenities, or for fees related to campsite/cabin reservations and registrations.

To qualify for an Access Pass, an applicant must be a resident of New York State, must provide proof of disability, in the form of certification from the appropriate agency or by a physician, as described on the attached application and must provide a recent photograph that will be affixed to the Access Pass.

Applicants must complete both parts 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.
PART ONE: Personal Information

Birth Date
Month Day Year

Social Security No.

XX X X

First Name

MI

Last Name

SUFFIX

Street Address

(A copy of the currently valid New York State Driver’s License or Non-
Driver’s Identification Card or New York State tax return (IT 201) for the preceding tax year
in the name of the applicant or, in the case of a minor, in the name of the legal guardian,
must be enclosed.)

City or Town

State

NY

Zip Code

Mailing Address (if different than street address)

City or Town

State

NY

Zip Code

Telephone Number

Email Address (optional)

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) Certification from the New York State Commission for the Blind and Visually Handicapped that I 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 from the New York State Office of Mental Retardation and Developmental Disabilities that I receive services from a program they license, operate, certify or fund

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(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) 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

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’s Signature _____________________________________________________________ Date _________________________________________________________

Physician’s Signature _____________________________________________ Date _______________________

Photographs and Certification cannot be returned.

TAPE a photo of the applicant taken within the past year in this space. Photo should be approximately 1” x 1-1/4”. Do not staple, glue or paperclip. Please write your name on the back of the photo. Photocopies of photographs cannot be accepted.