Application for Accessible Parking Space Program

DRIVER ONLY APPLICATION

RETURN COMPLETED APPLICATIONS TO:
Mayor’s Commission for Persons with Disabilities
Boston City Hall, One City Hall Square – Room 967, Boston, MA 02201
Phone: 617-635-3682 Fax: 617-635-2726 TTY: 617-635-2541

Information must be printed clearly, all questions must be answered completely, & supporting documentation must be included – incomplete applications will be returned, resulting in a delay of processing the application.

Today’s Date: ______________________ Application Type: NEW ☐ RENEWAL OF EXISTING SPACE ☐

1. APPLICANT INFORMATION (APPLICANT refers to the person with a disability who is in need of parking)

Last Name ______________________ First Name ______________________ Middle ______________________
Address ______________________ Neighborhood ______________________ Zip ______________________
Unit # ______________________ Date of Birth ______________________ Age ______________________
Phone ______________________ Email ______________________

In terms of operating the vehicle, is the applicant: The Only Driver ☐ The Primary Driver ☐ Only a Passenger ☐

** IMPORTANT – If you do not drive & are always a passenger, STOP here and fill out the PASSENGER APPLICATION **

How often does applicant leave home using this vehicle? Daily ☐ Weekly ☐ Other ☐ (how often? __________)

→ If “Daily,” describe where you go on a daily basis: ______________________________________________________

→ If “Other,” explain frequency you leave home using this vehicle: ____________________________________________

2. VEHICLE INFORMATION (VEHICLE must be registered and located at the applicant’s address)

Vehicle Make ______________________ Model ______________________ License Plate Number ______________________
MA-RMV Disabled Placard Number ______________________ Expiration Date ______________________
Applicant’s MA Driver’s License # ______________________ Expiration Date ______________________

→ A copy of each of the following documents is REQUIRED to be submitted with this application – Did you enclose:

- Copy of Vehicle Registration for a car located at the Applicant’s Address Yes ☐ No ☐
- Copy of Applicant’s Disabled Parking Placard (showing photo & expiration date) Yes ☐ No ☐
- Copy of Applicant’s Driver’s MA Driver’s License (showing photo & expiration date) Yes ☐ No ☐

Is this vehicle modified with adaptive equipment (ramp, lift, hand controls, etc?) Yes ☐ No ☐

→ If “Yes,” describe modifications: ________________________________________________________________

________________________________________
3. PROPERTY INFORMATION

Do you own the property where you are requesting the Accessible Space to be installed? Yes □ No □

Is there ANY off-street parking at this address, such as a driveway, parking lot, or garage? Yes □ No □

**IMPORTANT – You must report ALL existing off-street parking at this address even if you cannot use it**

→ If you answered “Yes,” are you able and/or allowed to use the off-street parking? Yes □ No □
→ If you CANNOT use the off-street parking, explain why: __________________________________________

Is this Public Housing? Yes □ No □ If “Yes,” Name of Development: ____________________________

Do you reside at this address year-round, without extended periods away? Yes □ No □

Are there any existing Accessible Parking signs posted in front of your residence? Yes □ No □

How many Accessible Parking Spaces are located on your block? 0 □ 1 □ 2 □ 3 □ Other □__________

Check off all parking restrictions at this address: No Parking □ Hydrant □ Bus Stop □ One-way Street □

What floor of this property do you live on? Basement □ 1 □ 2 □ 3 □ 4 □ Other □_______________

How do you get into your house / unit? Ramp □ Elevator or Lift □ Stairs □ (# of stairs________________)

4. DISABILITY INFORMATION

What is the medical DIAGNOSIS causing your disability? __________________________________________

What SYMPTOMS affect your ability to walk? __________________________________________________

How long is your disability expected to last? Permanently □ Temporarily □ (# of years______________)

How many city blocks can you walk without stopping to rest? ________________________________

Are you dependent on any mobility devices that your doctor wrote a PRESCRIPTION for? Yes □ No □

→ If you answered “Yes,” which devices? wheelchair □ portable oxygen □ prosthesis □ walker □ cane □
→ If you answered “Yes,” did you enclose the REQUIRED copy of this prescription? Yes □ No □

Are you employed? Yes □ No □

→ If you answered “Yes,” are you employed full-time or part-time? Full-time □ Part-time □
→ If you answered “Yes,” what is your occupation? ____________________________________________

5. AUTHORIZATION BY APPLICANT

I certify that the above information is true and accurate. I fully understand that the installation of Accessible Parking signs at my residence does not reserve a parking space for my personal use. It makes a space available for use by any vehicle with a valid Disabled plate or placard. I understand that abuse or violation of this agreement may result in removal of the Accessible Parking.

Applicant Signature ___________________________________________ Date __________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________
Application for Residential Accessible Parking Space Program
Medical Documentation Form

This form must be filled out completely by the applicant’s Primary Care Physician or a Licensed Specialist. Information must include the Physician’s registration number and their signature. Please type or print clearly.

Instructions for Physician: Your patient, named above, is applying for a Residential Accessible Parking Space (APS space) in the City of Boston. To qualify for this program, we need specific information from you about your patient’s medical diagnosis and functional limitations. A person must have a physical limitation which prevents them from getting to their home from an on-street parking space farther than one block away. Please read this form in its entirety and complete it accurately to the best of your knowledge ONLY for those patients who you have personally treated and diagnosed with a severely limited ability to walk.

Date: __________________________

Patient (Applicant) Name: ___________________________________________ Date of Birth: __________________________

Doctor’s Relationship to Patient:  PCP □ Specialist □ Other □ Specialty/Other: __________________________

Describe Patient DIAGNOSIS: __________________________________________

Is this a permanent condition? Yes □ No □

➔ If this condition is temporary, how long do you expect it to last? __________________________

Describe Patient SYMPTOMS: __________________________________________

How does this medical condition affect their ability to walk? __________________________

How many city blocks can this patient walk? 1 □ 1 ½ □ 2 □ 3 □ Other □ __________________________

Have you prescribed any medically necessary mobility devices for this patient? Yes □ No □

➔ If “yes,” which devices have you prescribed? wheelchair □ portable oxygen □ cane □ other □ __________________________

How long has this patient been under your care for this condition? __________________________

How often do you see this patient? Annually □ Monthly □ Weekly □ Other □ __________________________

Does this patient receive medical treatment / therapy outside of their home on a regular basis? Yes □ No □

➔ If ”Yes,” what treatment / therapy do they receive? __________________________

➔ How often do they leave their home for this treatment? Daily □ Weekly □ Other □ __________________________

*** A copy of your prescriptions for all mobility devices MUST be enclosed with application ***
Please check off any of the following medical conditions that accurately describe your patient’s disability:

- [ ] Lung Disease: Yes [ ] No [ ] Does this require the use of portable oxygen? Yes [ ] No [ ]
  Explain: ____________________________________________

- [ ] Class III or Class IV Cardiac Condition, according to the American Heart Association
  Explain: ____________________________________________

- [ ] Arthritis: Type of Arthritis ___________________________ Joints Affected: ___________________________
  Explain: ____________________________________________

- [ ] Other mobility impairment that requires the use of a medically necessary mobility device (wheelchair, scooter, prosthesis, walker or cane). A prescription for this mobility device must be included.
  Explain: ____________________________________________

Physician’s Name (printed clearly) ____________________________________________
Name of Hospital, Clinic of Medical Practice _______________________________________
Address of Medical Practice ___________________________________________________
Phone Number: ____________________________ Email: ____________________________

I hereby certify that the above information is true and accurate under the pains and penalties of perjury.

Physician Signature ____________________________________________
MA Board of Registration Number _______________________________________

FOR APPLICANT – PLEASE HAVE THIS SECTION COMPLETED BY A NOTARY PUBLIC

Commonwealth of Massachusetts

Ss, __________________________________________________________________________
County

Now comes ___________________________________, (name of applicant) who personally appeared before me and swore the foregoing to be both true and accurate.

Printed Name of Notary Public ___________________________________________________
Signature _______________________________________________________________________

Commission Expiration Date: ____________________________ STAMP HERE

Notary Public must stamp this application