REVISED May 1, 2014 – Previous Versions No Longer Valid

CITY OF BOSTON

OFFICIAL OFFICE USE ONLY:
☐ Approved: CRM_____
☐ Denied: Reason_____
☐ Appeal: ☐ Approved ☐ Denied
Staff: _____ Date: _____

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 ☐ → (how long?_____)**

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**

CITY OF BOSTON

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