REVISED May 1, 2014 – Previous Versions Not Valid

CITY OF BOSTON

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

Accessible Parking Space Program

PASSENGER 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

Today's Date: _____ **Application Type:** NEW ☐ RENEWAL OF EXISTING SPACE ☐

1. *APPLICANT INFORMATION* (*APPLICANT* refers to the disabled person who has an HP Placard and needs parking)

Last Name _____ **First Name** _____ **Middle** _____

Address _____ **Neighborhood** _____ **Zip** _____

Unit # _____ **Date of Birth** _____ **Age** _____

Phone _____ **Email** _____

Is Applicant a Child Under 18? **Yes** ☐ **No** ☐ **Does Applicant use a wheelchair full-time?** **Yes** ☐ **No** ☐

In terms of operating the vehicle, is the Applicant: Always a Passenger ☐ Always the Driver ☐ Sometimes Both ☐

***** IMPORTANT – If you are always or sometimes a driver, please STOP here and fill out the DRIVER APPLICATION *****

Is the Applicant Employed? **Yes** ☐ → **No** ☐ **If Applicant is employed, is it:** **Full Time** ☐ **Part Time** ☐

→ *If Applicant is employed, what is the occupation?* _____

How often does Applicant leave home using their vehicle? **Daily** ☐ ↓ **Weekly** ☐ **Other** ☐ (how often? _____)

→ *If "Daily," describe where you go on a daily basis:* _____

_____

2. *PRIMARY DRIVER INFORMATION* (Refers to the person who provides primary transportation to the *APPLICANT*)

Primary Driver Last Name_____ **Primary Driver First Name** _____

Address _____ **Unit #** _____ **Neighborhood** _____ **Zip** _____

Primary Driver Relationship to Applicant _____ **Is Primary Driver Employed?** **Yes** ☐ → **No** ☐

→ *If Primary Driver is employed, what is their work schedule?* **Full Time** ☐ **Part Time** ☐ **Other** ☐ _____

→ *What is Primary Driver's Availability to drive Applicant?* **Mornings** ☐ **Afternoons** ☐ **Evenings** ☐ **Weekends** ☐

Where does the primary driver drive the applicant? **Rides to work** ☐ **Shopping** ☐ **Doctor** ☐ **Other** ☐ →

→*Describe "Other" places driven (Must be SPECIFIC to support this application):* _____

_____

3. VEHICLE INFORMATION (This *VEHICLE* must be registered and located at the applicant's address)

Vehicle Make _____ **Model** _____ **License Plate Number** _____

Applicant's RMV Disabled Placard Number _____ **Expiration Date** _____

Primary Driver's MA License Number _____ **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 Primary 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*: _____

4. 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 CANNOT use the off-street parking, explain why:* _____

_____

Is this Public Housing? **Yes** ☐ → **No** ☐ *If "Yes," Name of Development*: _____

How many existing Accessible Parking ♿ signs are located on your block? **0** ☐ **1** ☐ **2** ☐ **3** ☐ **Other** ☐ _____

→ *Are there any existing Accessible Parking ♿ signs already posted in front of your residence?* **Yes** ☐ **No** ☐

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** ☐ **Other** ☐ _____ →

→ *How do you get into your house / unit?* **Ramp** ☐ **Elevator / Lift** ☐ **Stairs** ☐ → **# of stairs**_____

5. DISABILITY INFORMATION

What is your DIAGNOSIS? _____ **Is it: Permanent** ☐ **Temporary** ☐ → **(how long?**_____**)**

What SYMPTOMS affect your ability to walk? _____

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** ☐

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

Is there a MEDICAL reason you cannot be dropped off and picked up at your home by the primary driver? Yes ☐ → **No** ☐

→ *If you answered "Yes," Please explain in DETAIL* _____

_____

6. AUTHORIZATION BY APPLICANT

I certify that the above information is true and accurate. I understand that the Accessible Parking signs at my address do not reserve a parking space for my personal use. I understand that abuse or violation of this agreement may result in removal of these signs.

_____ _____

Applicant Signature **Date**

CITY OF BOSTON

Application for Resident 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 ******

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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