CITY OF BOSTON

DISABILITIES COMMISSION

Mayor Michelle Wu

Application for On-Street Accessible Parking Program

PASSENGER ONLY

Return to: Boston City Hall, One City Hall Square – Room 967, Boston, MA 02201
Phone: 617-635-3682 **Fax:** 617-635-2726 **TTY:** 617-635-2541

- If you are always or sometimes a driver, please stop here and fill out the Driver Application.
- Incomplete application will not be processed and will be returned.
- The application must be submitted within (60) days of the healthcare provider's certification.
- All required documents must be included.
- Additional documentation may be required.

*** IMPORTANT ***

The supporting documents listed below must be included with your application:

- ☐ Copy of Vehicle Registration showing address that matches applicant's residence
- ☐ Copy of Disabled Parking Placard clearly showing photo, ID #, and expiration date
- ☐ Copy of Driver's MA Driver's License showing photo and expiration date
- ☐ Medical Form signed by your doctor and dated within 60 days of the application

All your information should be printed clearly and legibly, including the Medical Documentation Section completed by your doctor. Our office does not have any physicians on staff to evaluate applicants' disabilities. We rely on your doctor's assessment of your qualifications, so please do not send us any medical records, test results, x-rays, or photographs of your physical condition. Applications may take up to 4 to 6 weeks to process, depending on various circumstances and conditions. You will be notified by mail or email of approval or denial.

***** Keep a copy of your completed application & supporting documents for your records *****

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

First Name________________________ Middle Initial________ Last Name____________________________

Date of Birth ___________________ Phone Number ______________________________

Email (Required) ____

Residential Address (Where you actually reside)

Address _________________________________ Neighborhood ___________________ Zip Code ________

Mailing Address (if different)

Address _________________________________ Neighborhood ___________________ Zip Code ________

Is the applicant employed? ☐ Yes ↓ ☐ No

→ If "Yes," is the applicant employed full-time or part-time? ☐Full-time ☐Part-time

→ If "Yes," what is the applicant's occupation? ____

2. PRIMARY DRIVER INFORMATION (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 the Primary Driver's Availability to drive the Applicant? ☐Mornings ☐ Afternoons ☐Evenings ☐Weekends

How often does the Applicant leave home using this vehicle? ☐ Daily ☐ Weekly ☐Other (how often? ____________)

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

____

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 ____________________

Applicant's MA Driver's License #__________________________ Expiration ____________________

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

→ If "Yes," describe modifications: ____

3. PROPERTY INFORMATION

Does the applicant or a relative 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 allowed to use the off-street parking? ☐Yes ☐ No

→ If you CANNOT use the off-street parking, explain why: __________________________________

____

Does the applicant 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 the 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 does the applicant live on? ☐ Basement ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐Other ____________

→How does the applicant get into their house / unit? ☐ Ramp ☐ Elevator or Lift ☐Stairs (# of flights of stairs ________)

4. DISABILITY INFORMATION

What is the applicant's disability? ____

Is the applicant's disability: ☐ Permanent ☐ Temporary (how long? ____________)

What SYMPTOMS affect the applicant's ability to walk?____

How many city blocks can the applicant walk without stopping to rest? ______________

Is there a MEDICAL reason the applicant cannot be dropped off and picked up at their home by the driver? ☐Yes ☐ No

If "Yes," Please explain in DETAIL ____

Are you dependent on any mobility devices? ☐Yes ☐No

→ Which devices: ☐ Wheelchair ☐ Portable Oxygen ☐ Prosthesis ☐ Walker ☐Cane ☐Other ______________

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 misuse or violation of this agreement may result in removal of the signs.

______________________________ ______________________________

Applicant Signature Date

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On-Street 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 Provider: Your patient, named below, is applying for an On-Street Accessible Parking Space (aka Accessible Space) near their home 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.

Patient (Applicant) Name: ____________________ Date of Birth: ____________

Clinical Diagnosis (Required): ______________________________ (NO ICD CODES)

Describe Patient SYMPTOMS: ______________________________

Duration of patient's disability (Check One): × Permanent × Temporary (How long? ____________)

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 __________

Healthcare Provider Certification and Signature (Required)

I am: ☐ Medical Doctor ☐ Chiropractor ☐ Registered Nurse ☐ Physician Assistant ☐ Other ____

Provider's Name (printed clearly): ______________________________

MA Board of Registration Number: ______________________________

Phone Number: ______________________________

Name of Hospital/Clinic of Medical Practice: ______________________________

Address of Medical Practice: ______________________________

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

______________________________ ______________

Provider Signature Date