CITY OF BOSTON

DISABILITIES COMMISSION

Mayor Michelle Wu

Application for On-Street Accessible Parking Program

DRIVER 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

- Incomplete application will not be processed and will be returned.
- The application must be submitted to the Disability Commission 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 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 _____

Are you employed? ☐ Yes ↓ ☐ No

→ If "Yes," are you employed full-time or part-time? ☐ Full-time ☐ Part-time

→ If "Yes," what is your occupation? _____

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: _____

_____

How often do you leave home using this vehicle? ☐ Daily ☐ Weekly ☐ Other (how often? _____)

→ Describe where you go using your vehicle: _____

_____

3. PROPERTY INFORMATION

Do you 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: _____

_____

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 flights of stairs _____)

4. DISABILITY INFORMATION

What is your disability? _____ Is it: ☐ Permanent ☐ Temporary (how long?_____)

What SYMPTOMS affect your ability to walk? _____

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

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

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

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

Revised April 2022. Previous versions no longer valid.

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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