CITY OF BOSTON

DISABILITIES COMMISSION

Mayor Michelle Wu

Application for On-Street Accessible Parking Space Program

RENEWAL 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 (30) days of the notice for renewal.
- 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

All your information should be printed clearly and legibly. 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 _____

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

→ Please describe where you go: _____

_____

3. DISABILITY INFORMATION

What is your disability? _____

Is it: ☐ Permanent ☐ Temporary (how long? _____)

What SYMPTOMS affect your ability to walk? _____

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

4. ADDITIONAL INFORMATION

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

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

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

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

DISCLAIMER:

The City of Boston On-Street Accessible Parking Space Program is a joint program run by the Mayor's Commission for Persons with Disabilities and the Boston Transportation Department to accommodate residents with extreme functional limitations in their ability to walk. The program criteria differ from criteria used by the Massachusetts Registry of Motor Vehicles, and possession of Disability Plates or a Disability Placard issued by the Registry does not guarantee approval of a Residential Accessible Parking Space. Some disabilities and / or medical conditions may not qualify the applicant for installation of an Accessible Parking Space. The City's Disability Commissioner has the authority to approve or deny application according to her discretion. Accessible Parking Spaces are available for use by anyone with a valid Disability Plate or a Disability Placard issued by the MA RMV, or issued by another state.

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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