

OFFICIAL OFFICE USE ONLY:

Approved: CRM _____
 Denied: Reason _____
 Appeal: Approved Denied
Staff: _____ Date: _____

CITY OF REVERE



Accessible Parking Space Program (HP Sign)
PASSENGER ONLY APPLICATION
RETURN COMPLETED APPLICATIONS TO:
Revere City Hall
Attn: Revere Commission on Disabilities
281 Broadway Revere, MA 02151
Phone: 781-286-8267 Email: disabilities@revere.org

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 _____ Zip _____

Unit # _____ Date of Birth _____ Age _____

Phone _____ Email _____

Is Applicant a Child Under 18? Yes No Does Applicant need or use a wheelchair full-time? Yes No

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:

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****

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 # _____ 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 (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:

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 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 _____)

5. 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?

6. 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 _____