HANDICAP PARKING SPACE APPLICATION

Please read the attached application carefully.
Complete this form, and return along with a copy of your vehicle registration to:

BOROUGH OF FOUNTAIN HILL
941 Long Street
Fountain Hill, PA
18015

Also attached is a **Physician's statement** form which must be completed, certifying the nature of your disability and accompany the application.

To qualify for Handicapped Parking the following criteria must be met:

1. Applicant and/or disabled person must reside at the address where the vehicle is registered.

2. Vehicle must have one of the following:

   a. *HP PLATE*
   b. *DISABLED VETERAN'S PLATE*

3. Applicant and/or disabled person cannot have off-street parking readily available (garage, driveway).

4. The disabled person must have a disability that strictly restricts ambulation.

5. *Notification to Neighbors* form must be completed.

Please note: The *Physician's Statement* must be PRINTED OR TYPED, or the application will be returned without approval.

Applicant must submit a copy of their valid vehicle registration and proof of financial responsibility (insurance card) when submitting application.

If approved, the cost to place the handicapped parking sign will be $350.00.

APPLICANT INFORMATION

Name of Applicant:______________________________ Phone#____________
(Please Print)

Address:______________________________

Is Applicant Disabled? () Yes () No (Please check)

If NO, name of disabled person:______________________________
(Please Print)

Relationship to Disabled Person:______________________________

VEHICLE INFORMATION

License Plate # ____________________

Is the driver of vehicle disabled?
( ) Yes ( ) No (Please Check)

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Describe your disability:______________________________

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2. Explain why you feel you need a handicapped parking space:______________________________

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3. Do you ambulate with one of the following? (Please check)

a. Wheelchair	( )	d. Cane	( )
b. Crutches	( )	e. Braces	( )
c. Walker	( )	f. OTHER	() Please specify below:

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4. Do you have off -street parking ? Yes __ No __

If yes, please check: Garage ( ) Driveway ()

PHYSICIAN'S STATEMENT MUST BE **PRINTED** OR **TYPED**

Patient's Name:____

a. Please describe the patient's disability:______________________________

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b. Please explain in detail why you feel the applicant should have reserved handicap parking in front of his or her home: ____

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c. If the applicant's diagnosis is heart disease, please check the below classification:

( )Class I — Patients with cardiac disease but without resulting limitations of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or angina pain.

( ) Class II — Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or angina pain.

() ClassIII — Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary physical activity causes fatigue, palpitation, dyspnea, or angina pain.

( )ClassIV — Patients with cardiac disease resulting in inability to cany on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

d. Is the patient restricted by lung disease? () YES () NO

{a) If yes, is patient restricted to the extent that the patient's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter or the arterial oxygen tension is less than 60mm.Hg on room air atrest?

() YES ()NO

(b) Uses portable oxygen: () YES () NO

Physian's Statement (continued)

e. Can the applicant walk 200 ft. on an even surface without stopping to rest?
() YES () NO

f. Is patient's disability permanent? ( )YES ( ) NO
If no, what is patient's prognosis for recovery:.________________________________

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g. If the patient is not the driver of the vehicle, can patient safely stand alone at the curbside unassisted?
( )YES ( )NO

h. In your professional opinion, do you feel applicant qualifies *for* a handicap parking space on the street at or near his/her home?
( )YES () NO

COMMENTS:

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Physician's Name:________________________________

(Print or Typed)

Address:________________________________ Phone#________________

Physician's Signature:________________________________

WAIVER OF APPLICATION FEE

I hereby certify that I am eligible for a waiver of the application fee. Please check off the appropriate boxes:

Household Size	1	2	3	4	5	6	7	8
Income Below (2002 HHS Poverty)	**$8,860.**	**S11,940**	**$15,020**	**$18,100**	**$21,180**	**$24,260**	**$27,340**	**$30,420**

Please submit a copy of your most recent Federal Tax Return.

NAME

SIGNATURE

DATE