



**Philadelphia
Parking
Authority**

3101 Market Street
Philadelphia, PA 19104-2807
(215) 683-9600

Dear Applicant:

Enclosed is an application for Residential Parking for People with Disabilities (RPPD). It is very important that this application be filled-out completely and legibly. An application which is incomplete, illegible or otherwise not filled out in compliance with the explicit instructions given on the application will be returned to the applicant without action.

Upon our receipt of your completed application, you will be sent an acknowledgment card. We will then evaluate and verify the information and do an on-street investigation to insure that traffic restrictions do not prohibit installation of a RPPD zone at the location you have requested.

Additionally, we will mail a Physician's Certification of Disability form to the physician(s) you have listed on your application. Upon completion of the certification of disability, your physician will be required to return the document to the City of Philadelphia's Department of Health where it will be carefully evaluated and determined if your disability warrants approval of your application.

You will be notified in writing as to whether your application has been approved or denied.

If you have any questions, please contact us at 215 683-9736.

Thank you,

Residential Parking for People
with Disabilities Unit

FUNCTIONAL GUIDELINES AND ELIGIBILITY CRITERIA
RESERVED RESIDENTIAL PARKING FOR PEOPLE WITH DISABILITIES

It is the responsibility of the medical evaluator to determine whether the one or more medical conditions ascribed to an applicant are of such severity as to render the applicant disabled to the extent that reserved parking is required for him or her to function adequately on a day to day basis. The following is a rather comprehensive list of medical conditions which, in various stages cause moderate to severe mobility impairment. Most sections include a "Note" area to assist the evaluator in interpretation of the medical criteria as they relate to an applicant's eligibility for reserved, residential parking for people with disabilities.

PHILADELPHIA HEALTH DEPARTMENT

SECTION 1

Non - Ambulatory Disabilities

Impairments that require the applicant to use a wheelchair for mobility.

SECTION 2

Impaired or Assisted Ambulation

Intended for those who walk with extreme difficulty including those individuals who use a walker, crutches or leg braces. Use of a cane does not necessarily indicate eligibility for reserved residential parking.

Note: Claiming eligibility under this section will require extensive medical documentation or an additional medical examination of the individual to determine whether or not this applicant's medical condition qualifies the applicant for receipt of a reserved residential zone.

SECTION 3

Arthritis

This section is intended for people whose arthritic condition makes walking extremely difficult; people who suffer arthritis which causes a severe functional motor deficit in the legs.

Functional Capacity

Class III - Functional capacity adequate to perform only a few or none of the duties of usual occupation or self care.

Class IV - Largely or wholly incapacitated, uses wheelchair.

Mobility Assessment

Grade II - The applicant can cross the road but cannot manage public transportation.

Grade III - The applicant can use stairs but cannot cross roads.

Grade IV - The applicant cannot use stairs.

Grade V - The applicant can move from room to room with help.

Grade VI - The applicant is confined to chair or bed.

Note: Arthritis alone can only be used as a criterion for reserved residential parking if the applicant meets Class III under the Functional Capacity section and at least Grade III and up to Grade V under the Mobility Assessment section. Those applicants falling under other classes or grades listed must have either additional medical complications (when considering those at Grade II level) or traffic and/or terrain problems creating additional hardships for an attendant or driver of the disabled resident (when considering those at the Class IV and Grade VI levels.)

SECTION 4

Amputation/Anatomical

This section is intended for people who find it extremely difficult to walk because of amputation, congenital absence of or anatomical deformity of the lower extremity at or above the tarsal region of one or both legs.

Note: Exceptions might include those cases in which the applicant has been particularly successful in mastering life skills and has been rendered fully ambulatory with the aid of his/her prosthesis.

SECTION 5

Cerebrovascular Accident

This section is intended for those applicants who, because of stroke or brain injury find it extremely difficult to walk. These applicants must exhibit one of the following:

(A) Severe functional motor deficit in any of two extremities

(B) Severe ataxia affecting two extremities substantiated by appropriate cerebellar signs of proprioceptive loss/loss of muscle and kinesthetic sense.

Note: Appropriate medical documentation including, but not limited to rehabilitation records, etc. required before approval of an application from an individual falling under this category.

SECTION 6

Pulmonary Disabilities

People who, because of a respiratory condition, find it extremely difficult to walk. These individuals experience dyspnea at various levels of exertion. Applicants must exhibit one of the following:

- (A) Dyspnea which occurs during such activities as climbing one flight of stairs or walking 100 yds on level ground.
- (B) Dyspnea present on the slightest exertion such as dressing, talking or at rest.

Note: Applicants for reserved parking may qualify under either sections A or B, however, these conditions should be substantiated by respiratory function studies or by other objective rather than subjective evidence. If oxygen is required to carry out routine functions, this should be stated by the applicant's physician.

SECTION 7

Cardiovascular Disease

This section applies to those individuals who, because of cardiac illness, walk with extreme difficulty. This includes people who exhibit Class III or Class IV in the functional classification and Class D or E in the therapeutic classification.

Functional Classification

Class III - Patients with cardiac disease resulting in marked limitation of physical activity. Patients may be comfortable at rest, however, less than ordinary physical activity causes fatigue, palpitations, dyspnea or anginal pain.

Class IV - Patients with cardiac disease resulting in an inability to carry out physical activity without discomfort. Symptoms of cardiac insufficiency or anginal syndrome may be present even at rest. Any physical activity will increase discomfort.

Therapeutic Classification

Class D - Patients with cardiac disease whose ordinary physical activity should be markedly restricted.

Class E - Patients with cardiac disease who should be at complete rest, confined to a bed or chair.

Note: Those applicants who fall under Therapeutic Classification D may or may not be mobility impaired to the extent that reserved parking is required. However, placement in this classification, along with inclusion under one of the other disability categories may combine to categorize the applicant disabled to the degree that a reserved parking zone is necessary. With respect to Therapeutic Classification E, the evaluator must bear in mind that persons who are confined to bed do not usually require the provision of special parking. Upon appeal however, special circumstances such as traffic or terrain problems may be brought to light which allow approval of reserved parking zones in such cases.

SECTION 8

Neurological Disabilities

This section is intended for those people who, because of impairment of the central nervous system, are disabled to the extent that their gait is radically altered resulting in severely restricted mobility.

Neurological Disorder: Damage to the central nervous system due to illness, accident, genetic or hereditary factors.

Note: Each of the factors above could cause a wide range of damage to the central nervous system resulting in anything from minor disability to total incapacitation. The evaluator must take care to detail the extent to which the applicant's mobility is impaired as a result of the resulting neurological disorder. The general rule for our purposes is if the applicant can walk one half of a city block without difficulty, he or she is not likely to require reserved residential parking.

SECTION 9

Other

Upon special request, consideration will be given to a disability which is not specifically included in the aforementioned criteria.

APPLICATION FOR RESERVED RESIDENTIAL PARKING FOR PEOPLE WITH DISABILITIES
THE PHILADELPHIA PARKING AUTHORITY
3101 Market Street • Philadelphia, Pennsylvania 19104-2807
215 683-9736 • 215 683-9809 (Fax)

If a parent, guardian or spouse is filling out the application for a child or relative, please list the child or relative as the applicant.
(Please print.)

Applicant's Name _____

Address (Own _____ Rent _____) _____ Zip Code _____

Telephone _____ Date of Birth _____ Social Security# _____

Occupation _____

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY:

1. What is the nature of your disability? _____

2. Explain why you are in need of reserved parking in front of your home. _____

THE ANSWERS TO THE FOLLOWING QUESTIONS WILL BE VERIFIED:

3. Do you have a garage or other off street parking available? (circle one) Yes No

4. Pennsylvania license plate number of the vehicle you use (HP/PD/DV ONLY) _____

PLEASE ATTACH PHOTOCOPIES OF YOUR VEHICLE REGISTRATION AND DRIVER'S LICENSE

5. In whose name is the vehicle registered? _____

6. If the vehicle is not yours, why are you requesting a zone for a vehicle not registered to you? Please be specific.

7. Is your property wide enough to accommodate a signed parking zone, 20 feet in length? (circle one) Yes No

If the answer to #7 is no, please have your next door neighbor read and complete the consent portion below.

Sign Installation Agreement: I understand that if the front of my home is not 20ft - 22ft from property line to property line, it is my responsibility to obtain the signature of the owner of the adjacent property indicating that they have no objections to the installation of this zone. I further agree that if I use this zone for any purpose other than that which I described in this application, the zone will be removed. I also agree that the Philadelphia Parking Authority retains the right to remove this zone at any time.

CONSENT OF ADJACENT PROPERTY OWNER (Please read carefully if applicable)

I, (print name) _____ certify that I am the owner of (state your address) _____
_____. I understand that my neighbor is in need of additional footage in order to install a reserved parking zone on the street. I have no objections to the City of Philadelphia installing a sign on the sidewalk in front of my property. I am aware that the footage required may be as little as 2ft to a maximum of 15 ft depending on the width of my neighbor's home.

Signature _____ Telephone _____

Date _____

POLICY STATEMENT

A reserved parking space in front of a residence is a special privilege granted by the City of Philadelphia only to people who have severe physical disabilities. Such a space will be granted only to those who are mobility impaired to the extent that they cannot manage without it. These zones will be reviewed at least once every three years.

PHYSICIAN'S LIST

Please provide for us the name of the physician most familiar with your physical disability. This physician will be mailed a "Physician's Certification of Disability" form by the Philadelphia Parking Authority on behalf of the City's Department of health. After the form is completed and returned by your physician, it will be reviewed and approved or denied by a panel of physicians from Moss Rehabilitation, Inc. Moss Rehab, Inc., a professional corporation, is under contract to the City of Philadelphia and the Philadelphia Parking Authority to provide this service.

Physician's Name _____ Address _____

City and State _____ Zip _____

Telephone _____ FAX _____

Additional information: _____

RELEASE OF APPLICANT'S MEDICAL RECORDS

I, _____, residing at _____,
Name Address

hereby authorize the above named medical provider(s) to release my medical records to:

The City of Philadelphia Health Department, the Philadelphia Parking Authority and its affiliated agencies

Signature of Applicant Date

APPLICANT'S CERTIFICATION

I am aware that it is my responsibility to file a **complete** application. I understand that the application will be returned to me if it is found to be incomplete, illegible, or otherwise not filed in compliance with the instructions. I further agree to submit to an independent examination by a physician from the City of Philadelphia's Department of Health if required.

I certify that the information contained herein is true and correct to the best of my knowledge and belief. I understand that any false statements made herein are subject to the penalties of 18 Pa. C.S. Section 4904, relating to unsworn falsifications to authorities.

Executed on _____ at _____
Date City and State

Signature of Applicant

**PHYSICIAN'S CERTIFICATION OF DISABILITY
RESERVED RESIDENTIAL PARKING FOR PEOPLE WITH DISABILITIES**

The purpose of this program is to provide reserved residential on street parking to applicants whose mobility is limited to such a degree, by one or more medical conditions, that parking is required to allow the applicant to continue to function independently. The treating physician may be contacted by a physician from the City of Philadelphia's Department of Health. All descriptions and explanations concerning the applicant's level of disability, diagnosis and prognosis must be **MEDICALLY EXPLICIT**. Applications will be reviewed by a City of Philadelphia physician.

Please return the completed Certification of Disability to:

City of Philadelphia
Department of Health
P.O. Box 38743
Philadelphia, Pa 19104 - 8743

Please Type or Print Clearly

Name of Applicant: _____

Residential Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone _____ Work Telephone _____

The undersigned hereby certifies as follows:

1. I examined the above named applicant on the _____ day of _____, 19 __

2. Disability Status(check all that apply):

Please refer to functional guidelines sheet which is enclosed.

_____ Impaired or Non Ambulatory Disability(Sec. 1 and 2)

_____ Neurological(Sec. 8)

_____ Amputation/Level and Site(Sec. 4)

_____ Cerebrovascular Accident(Sec. 5)

_____ Cardiovascular(Sec. 7)

_____ Arthritis (Sec. 3)

_____ Pulmonary(Sec. 6)

_____ Functional Class.

_____ Functional Class.

_____ (A)

_____ Mobility Grade

_____ (B)

Other(Sec. 9)(Please specify): Diagnosis: _____

3. Please specify date of onset of applicant's disability: _____

4. Please describe in detail the nature and extent of the applicant's disability; focus on mobility limitations: _____

5. Examination findings pertinent to the applicant's mobility: _____

6. I performed the following test(s) /procedures diagnosing the applicant's disability:(include results) _____

7. Please specify the diagnosis and prognosis of the applicant: _____

8. Does the applicant require the use of any of the following mobility aids?(check all that apply) _____ Wheelchair
_____ Crutches _____ Scooter _____ Cane(s) _____ Walker _____ Braces (Type of
_____ Artificial limbs _____ Oxygen
_____ Brace)

Other (Please specify): _____

9. Is the applicant able to walk one half block without assistance of another person? Yes No

10. Does applicant require assistance with entering and exiting a vehicle? Yes No
If yes, please describe in detail: _____

11. Does applicant require assistance in entering or exiting his or her home? Yes No
If yes, please describe in detail: _____

12. Is the applicant capable of driving? Yes No
If yes, is the applicant the principal driver of the vehicle? Yes No

13. Will applicant's current level of disability (circle one): Improve? Remain the Same? Deteriorate?

I am a board certified physician in the following areas: (Please list and explain in detail) _____

I certify that the information contained herein is true and correct to the best of my knowledge and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. Sec. 4904 relating to unsworn falsification to authorities.

Executed on _____ at _____

by(Signature) _____

Please Print:

Name _____

Address _____ City and State _____

Zip Code _____ Telephone / Area Code _____