Township of Chester

1150 Engle Street
Chester, Pennsylvania 19013
(215) 494-4149

APPLICATION FOR HANDICAPPED PARKING ZONE

RETURN ALL COMPLETED APPLICATIONS TO THE TOWNSHIP OF CHESTER, 1150 ENGLE STREET, CHESTER, PA 19013

1. THE APPLICATION - Applicant must fill out page No. 1 & 2, all questions from (1) to (13) must be completed by applicant.
2. PHYSICIANS CERTIFICATION - Applicant must have page No. 3 filled out by his/her family physician or physician of his/her choice. Physician is asked to fill out page No. 3 and may use pages 4,5,6 for eligibility criteria. Physician is asked to sign page No.3 to certify applicants disability and need for HANDICAPPED PARKING ZONE.
3. STATE ISSUED LICENSE PLATE - Applicant must have special license plate issued by State of Pennsylvania with HP or DV on same designating (handicapped person) or (disabled veteran).
4. COMPLETED APPLICATION - Applicant shall submit the completed application from pages No. 1, 2, 3, to the Township of Chester, 1150 Engle Street, Chester, PA 19013, in person or by mail.
5. VERIFICATION - INVESTIGATION - After your application has been received by Township of Chester, it shall be checked for completion, then if completed it shall be verified and investigated. If not completed it shall be returned to applicant for completion. Only fully completed applications will be verified or investigated.
6. NOTIFICATION - Applicant shall be notified of approval or denial of his/her request. If approved signs will be placed at requested area, and street shall be marked. The area will then be designated HANDICAPPED PARKING ZONE ONLY, no other vehicles may park in this zone.

7. USE OF HANDICAPPED PARKING ZONE - Applicant may park only the vehicle registered with HP or DV license in the HANDICAPPED PARKING ZONE. No other vehicle may park in this zone, and zone may not be used for any other purpose by applicant or any other person or vehicle. If applicant uses zone for any purpose or manner other than as stated in request, the permit and zone shall be removed by Township of Chester. Also the Township of Chester shall retain the right to access of zone, and removal of same if applicant is in violation of use.

8. DURATION OF HANDICAPPED PARKING PERMIT - Each application approved shall be issued for two (2) year period only. Starting as of date of issue for a period of two (2) years to date of expiration. A copy of this HANDICAPPED PARKING ZONE PERMIT will be issued to each applicant if approved.

9. RENEWAL OF HANDICAPPED PARKING PERMIT - All new applicants and persons who have been issued a HANDICAPPED PARKING ZONE in past years, must submit a completed HANDICAPPED PARKING ZONE REQUEST form No. HPR-10. All applicants must renew permit ten (10) days prior to expiration date on permit. Ten (10 working days) as of this date all previous HANDICAPPED PARKING ZONES shall be due for renewal. If not renewed the zone will be removed by Township of Chester.

EASE PRINT BELOW DATE _____

PLICANT'S NAME _____ PHONE NO._____

PE OF RESIDENCE: Single Home___ Semi-detached___ Row Home___ Apartment___

Other___ (if other, list type)_____

I AM A RESIDENT OF THE TOWNSHIP OF CHESTER AND THE OWNER/OCCUPANT OF E ABOVE PROPERTY. I REQUEST THE INSTALLATION OF A HANDICAPPED PARKING NE TO BE LOCATED AT: _____

(Exact location of parking zone requested)

IS ZONE WOULD ASSIST ME DUE TO MY DISABILITY.

PLICANT PLEASE ANSWER THE FOLLOWING QUESTIONS

What is the nature of your disability? _____

_____

Explain why you feel you need a HANDICAPPED PARKING ZONE? _____

_____

_____

E FOLLOWING QUESTIONS WILL BE VERIFIED:

Do you use a wheel chair? Yes___ No___

If no, do you use implement to aid mobility? Yes___ No___

Type of implement used - Crutches___ Cane___ Braces___ Other_____

Do you have a garage or off street parking available? Yes___ No___

Is your property 20 feet wide or more? Yes___ No___ Unknown____

Is the location you requested for HANDICAPPED PARKING ZONE located in front or rear of your residence? Yes___ No___ If no, where is the requested area in relationship to your residence? _____

_____

Is the street in front or rear of your residence a no parking or limited parking area? Yes___ No___ (If yes, list type of parking) _____

_____

I agree that if I use this zone in any manner other than that which I have described at the time of application, the zone will be removed.

In addition I agree that the Township of Chester retains the right to remove this Zone at any time.

Vehicle license must be State of Pennsylvania issued HP or DV only.

License State _____ License No. _____

HANDICAPPED PERSON _____ DISABLED VETERAN_____

Vehicle year _____ Make_____ Model_____

The above vehicle is owned by: _____

_____

Address: _____

Relationship to you if not your vehicle? _____

Do you operate a motor vehicle? Yes___ No___ (If yes, complete)

Driver's license state _____ License No. _____

I certify that I have read this form and understand same. Yes___ No___

f no, explain)_____

I further state that I have answered all questions correctly to the best of my knowledge, and I agree to abide to terms of use of same if approved. I understand this special parking permit is issued for a two (2) year period only, and I must renew same before expiration date.

_____ X_____

Date Signature of Applicant

_____

Print name same as above

THIS SECTION TO BE FILLED OUT BY YOUR FAMILY PHYSICIAN

APPLICANT'S NAME _____ DATE _____

APPLICANT'S ADDRESS _____

The above named person has requested a HANDICAPPED PARKING ZONE in front of his/her residence. This is a special privilege granted by the Township of Chester only to people who have severe physical disabilities. Such area will only be granted to those who cannot manage without it.

A. Please indicate the above applicant's disability (Refer to Eligibility Criteria) Section No. _____

_____

_____

_____

B. Please describe disability in detail (In accordance with Eligibility Criteria) Section No. _____

_____

_____

_____

_____

C. Is the applicant the driver of the vehicle? Yes ___ No ___

If no, what is the relationship of the applicant to the driver?

_____

_____

D. Does the above applicant need to be lifted in and out of the vehicle?

Yes ___ No ___ _____

E. Can the above applicant walk more than one block without difficulty?

Yes ___ No ___ _____

X _____

Signature of family physician

_____

Office Address

Phone No. _____ _____

F. The above applicant is disabled and does qualify for HANDICAPPED PARKING ZONE. Yes ___ No ___ Other _____

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HANDICAPPED PARKING ELIGIBILITY CRITERIA

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 walkers, crutches, and/or long leg braces. (Use of a Cane does not necessarily indicate eligibility for HANDICAPPED PARKING).

SECTION 3. ARTHRITUS

This section is intended for persons who arthritic condition makes walking extremely difficult. Persons who suffer arthritis which causes a severe functional motor deficit in the legs. This section includes individuals who exhibit CLASS III or IV in the functional classification or grades II-VI in the mobility assessment.

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 a wheel chair. (Persons who are confined to bed do not usually require the provision of HANDICAPPED PARKING).

MOBILITY ASSESSMENT

GRADE II - The applicant can cross streets, but cannot manage public transportation.

GRADE III- The applicant can use stairs, but cannot cross street.

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.

ECTION 4. AMPUTATION, ANATOMICAL

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

ECTION 5. CEREBROVASCULAR ACCIDENT (stroke)

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

A. Dyspnea which occurs during such activities as climbing one flight of stairs or walking 100 yards on the level, or less.

B. Dyspnea present on slighest exertion, such as dressing, talking at rest.

ECTION 7. CARDIAC ILLS

This section applied to individuals, who because of cardiac ills, walk with extreme difficulty. This section includes persons who exhibit Class III or IV in the functional classification.

FUNCTIONAL CLASSIFICATION

CLASS III - Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. However, less than ordinary physical activity causes fatigue, palpitation, dyspnea, or anginal pain. Example: Inability to walk one or more level blocks or climbing one flight of ordinary stairs.

CLASS IV - Patients with cardiac disease resulting in inability to carry out physical activity without discomfort. Systoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

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 bed or chair.

SECTION 8. NEUROLOGICAL HANDICAPS

This section is intended for persons who, because of their disability, find it extremely difficult to walk. This includes persons who exhibit any of the disabilities listed below and for whom that disability severely affects the individual's gait or restricts his/her mobility. These disabilities include:

Neurological disorder
Any damage to the central nervous system, whether due to genetic, hereditary, accident or illness factors.
(Note) These conditions do not necessarily include all brain dysfunctions, but rather must be determined only on the individual applicant's mobility skills.

SECTION 9. SPECIAL REQUEST

This section is for special request of family physician who believes his patient should have special consideration due to illness or disability not covered in this criteria.