APPLICATION FOR DISABLED PARKING SIGNS ON RESIDENTIAL STREETS
KANSAS CITY, KANSAS

Applicant’s Name: _______________________________________________________

Name of Disabled Individual: _____________________________________________

Address: ______________________________________________________________

Telephone number: (     )_________________    Cell: (     )_________________

Email: _________________________________________________________________

LOCATION FOR THE REQUESTED SIGN

Name of Street: _________________________________________________________

Address: ______________________________________________________________

USE OF DISABLED PARKING SIGN

Will the primary use of space be for applicant’s vehicle?    Yes _____  No _____

Will the primary use of space be for applicant’s visitors/clients?  Yes _____  No _____

BARRIERS TO ACCESSIBILITY

Do you live on an incline?    Yes _____  No _____

Do you have a driveway?    Yes _____  No _____

Will you need a ramp?    Yes _____  No _____

Are there obstacles such as steps, gutters, etc. that further prevents easy accessibility into your home?    Yes _____  No _____

Do you use an assistive device (wheelchair, walker, crutch, prosthetic device, etc.)?    Yes _____  No _____
DOCUMENTATION OF MEDICAL NECESSITY

PLEASE DESCRIBE THE SUBSTANCIAL LIMITATIONS THAT SUPPORT THE PERMANENT CONDITION (S)

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

The applicant must also obtain a statement from their physician explaining the necessity of the disable parking sign. This statement should include such information as the type of disability and if the physician views this as a PERMANENT CONDITION. This DOES NOT guarantee the establishment of the sign. You may attach any additional information with this application.

Physician’s name (print):_____________________________ Date: ______________________

Physician’s signature:_____________________________ Date: ______________________

READ CAREFULLY

The applicant understands that if disabled parking signs are established: (1) the space may be used by any and all persons displaying the proper license or placard; and (2) the space remains subject to any parking prohibitions that may be in effect in the same block. Please Note: If you are approved for residential signage it is your responsibility to notify our office of any changes to your residential status.

Applicant’s Signature: ______________________ Date: ______________________

RETURN TO:

HUMAN SERVICES DEPARTMENT

701 N. 7th Street Room 346

KANSAS CITY, KS 66101-3035

Staff Contact:

Greg Carr
Phyllis Wallace

(913) 573-5460

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