**ACROD PARKING PROGRAM**
**NATIONAL DISABILITY SERVICES WESTERN AUSTRALIA**

# ACROD Parking Program – Application Form Effective 1st July 2012

## Important Information to be read by all applicants

The ACROD Parking Program aims to support people with a significant mobility restriction to access the community.

## Eligibility Criteria

To be eligible for a disability parking permit, you must meet one of the following criteria:

- You are unable to walk and always require the use of a wheelchair; or
- Your ability to walk is severely restricted by a permanent medical condition or disability; or
- Your ability to walk is severely restricted by a temporary medical condition or disability.

If you do not meet at least one of the above criteria, you are not eligible for a disability parking permit. For further information, please contact the ACROD Parking Program on (08) 9242 5544.

## How to apply

- All applications must be endorsed by a Doctor or Occupational Therapist.
- A permit will not automatically be granted. All applications are subject to assessment by the
- Any person who obtains a disability parking permit by false statement or misrepresentation will have their permit cancelled.
- PART A (pages 1-3) of this form must be completed by the applicant.
- PART B (pages 4-5) of this form must be completed by a Doctor or Occupational Therapist. You may need to book an extended appointment to ensure your Doctor has sufficient time to complete Part B of this form.

## Administration Fee

An administration fee of **$20.00** must be submitted with each application. As this fee is **non-refundable,** you should carefully consider whether you meet the eligibility criteria before submitting your application.

## Completing this form

- Please complete this form in black ink.
- Print neatly in capital letters.
- Do not use a photocopied form as this interferes with processing.
- Place a clear 'X' inside the correct box.
- If you make a mistake, fill the entire box and mark the correct box.

**Place a clear cross inside the box.**
**If you make a mistake, fill the entire box**
**and mark the correct box.**

### Submitting your application

Send your completed application by post, email or fax.
**Post:** Acrod Parking Program, PO Box 1428, OSBORNE PARK DC WA 6916
**Email:** app@app.org.au **Fax:** (08) 9242 5044

### Processing time

Because of the high number of applications we receive, please be patient. Assessment of new applications will take a minimum of ten working days and may take up to one month if additional information is required from your Doctor / Occupational Therapist.

### Declined applications

If your application is not successful, information will be provided to you about our appeals process.

### General information

- For more information about the ACROD Parking Program, please visit our website www.app.org.au
  or phone (08) 9242 5544.
- To request more forms, email app@app.org.au or phone (08) 9242 5544.

### Privacy Statement

In accordance with National Privacy Principle (NPP04), information contained in the application form will not be disclosed to any other organisation. However, the ACROD Parking Program may use the general statistics for future planning. General statistical information does not identify any person. You may access your own information by written request. The ACROD Parking Program takes all reasonable steps to protect the identifying information it collects from misuse, unauthorised access and disclosure. For more information on your privacy and the Ten Privacy Principles go to: www.privacy.gov.au

### Contact details

**ACROD Parking Program**
**T** (08) 9242 5544 **F** (08) 9242 5044 **W** www.app.org.au **E** app@app.org.au

# Part A – To be completed by the applicant

## Part A - Applicant Details

**Mark with a cross**
**If you make a mistake, fill in the entire box, and mark the correct box.**

**Title:**
Mr
Mrs
Ms
Miss
Other

**Gender:**
Male
Female

**Print neatly in capital letters**
Surname:
Given Names:
Date of Birth:
*Note: A residential address must be provided
Unit Number:
Street Number:
Street Name:
Suburb:
Post Code:
Home Phone:
Mobile Phone:
Email:
Postal Address (if different from above)
Postal Address:
Suburb:
Post Code:

## Applicant Statement

**Please provide detailed answers and attach more information on a separate sheet or back page of form if required.**

**1. Mark the box that applies to your situation.**

- ☐ I am unable to walk and permanently require the use of a wheelchair.
  Go to page 3 to complete Part A.
- ☐ I permanently use a walking frame, crutches or other specific mobility aid.
  Go to question 2.
- ☐ I am temporarily using a wheelchair, walking frame, crutches or other specific mobility aid.
  Go to question 2.
- ☐ I do not use a mobility aid to walk. Go to question 3.

**2. For those who use a mobility aid, state what type you use.**

**How often do you use a mobility aid? State number in box below then go to question 4.**
Days per week?
Days per month?
Other?

**3. For those who walk without the assistance of a mobility aid, how often is your walking restricted? State number in box below.**
Days per week?
Days per month?
Other?

**4. How many metres can you walk before you stop to rest?**
This question must be answered. To help you measure a distance, the width of one car bay generally equals 2.5 metres.

**5. Describe how your body feels when you walk (e.g. weak, painful, wobbly)?**

**6. Describe how you walk (e.g. speed, balance or how you think you look to others when you walk).**

**7. How do you manage your condition (e.g. type of medication and dosage, past/future surgery, portable oxygen, exercise, therapy, specialist treatment)?**

**8. Recent Medical Reports**
Please attach copies of any recent medical reports (e.g. x-ray, medical/therapist's letters) relevant to your mobility in support of this application. Do not include original documents as these cannot be returned to you.

**Have you attached Reports and/or letters to this application?**

**9. I confirm that my signature verifies all of the following:**

**YES** I agree to be contacted by the ACROD Parking Program to provide further information if required.
**YES** The information contained in this form has been endorsed by my Doctor / Occupational Therapist who, in turn, may disclose information about me to assist with my application.
**YES** I agree that health professionals or service providers may disclose information about me to the ACROD Parking Program to assist with the assessment of my application.
**YES** The information in this application is correct to the best of my knowledge.

Signature:
Date:

**Part A – Payment details**

Applicants must include a **non-refundable** administration fee of **$20.00** with the application. The $20.00 payment is by:

Cheque/money order made payable to ACROD Parking Program, OR
Credit card with the following details.

**Please print neatly in capital letters.**
Credit Card Number:
Card Expiry Date:
Cardholder's Name:
Signature:
Contact Phone Number:

# Please ask your Doctor or Occupational Therapist to complete Part B of this form.

**Part B – To be completed by your Doctor or Occupational Therapist**

**Part B – Doctor/Occupational Therapist Statement**

**Eligibility Criteria**
Criteria 1: The applicant is unable to walk and always requires the use of a wheelchair; or
Criteria 2: The applicant's ability to walk is severely restricted by a permanent medical condition or disability; or
Criteria 3: The applicant's ability to walk is severely restricted by a temporary medical condition or disability.

**1. How long has the applicant been your patient?**

**2. State the applicant's primary and secondary diagnoses that impact on their ability to walk. Please indicate the date of each diagnosis.**

**3. Provide objective measurements indicating the severity of the applicant's condition (e.g. spirometry, echocardiogram, doppler studies).**

**4. If the applicant uses a walking aid, how long will they need it?**
Less than 6 months
6 to 12 months
1 to 2 years
2 to 5 years
Indefinite
Other:

**5. Is the applicant's ability to walk likely to improve following treatment, recovery or rehabilitation?**
Yes
No
Unsure

## 6. What is the expected duration of the treatment, recovery or rehabilitation?

Less than 6 months

6 to 12 months

1 to 2 years

2 to 5 years

Indefinite

Other:

## 7. Is surgery being considered for the applicant?

Yes

State type:

Expected date:

No

## 8. Further Comments

# Part B – Doctor/Occupational Therapist Identification

**Please print in neat capital letters using black ink or stamp these details in the space provided.**

Name:
Postal Address:
Suburb:
Postcode:
Registration Number:
Email:
Phone:
Fax:

I certify that I have seen the applicant in a professional capacity and my signature below verifies all of the following:

**YES** The information supplied within this application form is correct to the best of my knowledge.
**YES** The applicant has a significant mobility impairment.
**YES** I am not the applicant or an immediate family member of the applicant.
**YES** I agree to be contacted to verify the information contained in this form.
**YES** I understand that it is an offence to verify any false information provided in this application.

Signature:
Date:

**A permit will not automatically be granted. All applications are subject to assessment by the ACROD Parking Program. You may be contacted for further information.**

Applicant to send completed form (Part A and Part B) with payment by post, email or fax.
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**Email:** app@app.org.au **Fax:** (08) 9242 5044