

Disabled Persons' Blue Badge & Freedom Pass Application Form



Disability Services

London Borough of Southwark
PO Box 51504
London SE1 9ZU

Tel: 020 7525 2141
020 7525 2306
Fax: 020 7525 3210

Please select which of the following you are applying for (you can select more than one):

Blue Badge Complete Sections A, C1, C2, D & E

Disabled Person's Freedom Pass Complete Sections A, C, C3, D & E

If you require an Elderly Person's Freedom Pass please apply at the Post Office

Southwark Disabled Parking Permit Complete Sections A, B & E

Available to any Blue Badge holder with a car or who has a resident carer with a car

SECTION A: PERSONAL DETAILS

Mr / Mrs / Miss / Ms / Other

Surname

Forenames

Address 

Postcode

Telephone Number

Mobile Number

Email Address

Date of Birth (dd/mm/yyyy)

Current Age

If you are over 60, we will contact you to ensure that you are receiving all other benefits that you may be entitled to. If you do not want to be contacted, please tick this box.

Have you already applied for a Blue Badge or Freedom Pass (disabled)? Yes No

If yes, please give the date you applied

Do you already have a Blue Badge parking permit?

Yes No

If yes, please state which local authority issued the badge

SECTION B: DISABILITY PARKING PERMIT

Only complete this section if you are applying for a Southwark Disabled Parking Permit.

Blue Badge Number (if you already have one)

Expiry Date (dd/mm/yyyy)

Name of car owner

Car Registration

Make of car

Colour of car

SECTION C: ELIGIBILITY CRITERIA

C1: ALL APPLICANTS

Are you registered as blind under the National Assistance Act 1948? (P)

Yes No

Do you receive a Mobility Allowance or the higher rate mobility component of Disability Living Allowance? (P)

Yes No

C2: BLUE BADGE APPLICANTS ONLY

If necessary, please use extra sheets of paper for descriptions and return with this application form

Do you receive a War Pensioners' Mobility Supplement? (P)

Yes No

Was your vehicle supplied by a Government Health Department? (P)

Yes No

Do you have a vehicle from a Mobility scheme? (P)

Yes No

Please provide the name of your diagnosed medical condition and give as much information as possible to support your application. (P)

If necessary, please use extra sheets of paper to provide any other relevant information to support your application.

C3: FREEDOM PASS APPLICANTS ONLY

If necessary, please use extra sheets of paper for descriptions and return with this application form

Are you profoundly or severely deaf (hearing loss of at least 70dBHL)? (P) Yes No

Are you without speech (unable to communicate verbally in any language)? (P) Yes No

Do you have a disability, or have you suffered an injury, which has a substantial, long term and adverse affect on your ability to walk? (P) Yes No

If yes, please provide a name or a description of your disability or long term health problem and how long you have had the above condition. Please describe in as much detail as possible how your condition impairs your mobility. (P)

Are you someone who does not have arms, or has long-term loss of the use of both arms? Yes No

Do you have a learning disability? Yes No

If yes, are you known to Southwark's Community Disabilities Service? Yes No

Please provide name and contact details of your care manager/social worker if you have one.

Are you someone who, if they applied for the grant of a licence to drive a motor vehicle under Part III of the Road Traffic Act 1988, would have their application refused pursuant to section 92 of the Act (physical fitness) otherwise than on the grounds of persistent misuse of drugs or alcohol? Yes No

Please provide written confirmation from the DVLA that you would or have been denied a driving licence or written medical evidence supplied by your doctor (P)

Do you have a severe enduring and long term mental health condition? (P) Yes No

If yes, please state

Please provide an original copy of your Care Plan

What is the nature or description of your disability or long term health problem, and how long have you had the above condition?

Please describe in as much detail as possible how your condition impairs your ability to walk or substantially restricts your movements and include a description of any walking aids you use.

SECTION D: GP / HEALTH PROFESSIONAL DETAILS

We may need to contact your GP for a medical report, therefore please complete your GP's contact details below.

Name of GP

Address of GP

Telephone Number of GP

If you see other health professionals please complete their details below

Name of Doctor / Nurse

Address of Doctor / Nurse

Telephone Number of Doctor / Nurse

If you have a Social Worker / Care Manager please complete their details below

Name of Social Worker / Care Manager

Address of Social Worker / Care Manager

Telephone Number of Social Worker / Care Manager

SECTION E: DECLARATION

I declare that to the best of my knowledge all the statements I have made on this form are true. I authorise you to use the information that I have provided to process my claim for a Blue Badge, a Freedom Pass, or both. I agree that you may check this information with other organisations such as the Department for Work and Pensions, my GP, other health professionals or any other person named on this form. You may do this now and at anytime whilst I am in possession of a Blue Badge or a Freedom Pass.

I understand that you may give some information to other organisations, such as government departments and local authorities.

I know that I must let you know in writing about any change in my circumstances which might affect my claim.

I accept that if you find that I have provided false information you will withdraw the service and I may be prosecuted.

Name (print)

Signed

Date

Please ensure you have enclosed all the relevant documents as detailed in the guidance notes and 2 recent passport-sized photographs with your name printed on the back of each. If you do not enclose the relevant documents we will not be able to proceed with your application. In this case your application will be returned to you indicating what we need.

Office Use Only						
DLA	Start Date				Rate	
CTAX	Liable		yes		no	a/c number
	Comments					
Officer					Date	

SECTION F: EQUAL OPPORTUNITIES MONITORING (OPTIONAL)

To help us check that we are providing a service effectively and fairly, please mark the appropriate sections below. Completion of this section is voluntary. This will be treated in the strictest confidence and will be used purely for statistical monitoring and research. Do you consider your ethnic origin to be:

White		Mixed		Black	
British	<input type="checkbox"/>	White & Black Caribbean	<input type="checkbox"/>	Black British	<input type="checkbox"/>
Irish	<input type="checkbox"/>	White & Black African	<input type="checkbox"/>	Caribbean	<input type="checkbox"/>
Any other white background	<input type="checkbox"/>	White & Asian	<input type="checkbox"/>	African	<input type="checkbox"/>
		Any other mixed background	<input type="checkbox"/>	Any other background	<input type="checkbox"/>
Asian		Any other ethnic group			
Asian British	<input type="checkbox"/>	Chinese Vietnamese	<input type="checkbox"/>		
Indian	<input type="checkbox"/>	Cypriot Greek	<input type="checkbox"/>		
Pakistani	<input type="checkbox"/>	Cypriot Turkish	<input type="checkbox"/>		
Bangladeshi	<input type="checkbox"/>	Cypriot other	<input type="checkbox"/>		
Any other Asian background	<input type="checkbox"/>	Any other ethnic group	<input type="checkbox"/>		