

**TOWN OF CHESHIRE, CONNECTICUT**  
**RESIDENTIAL SOLID WASTE PROGRAM**  
**DISABILITY APPLICATION FOR NON-CURBSIDE COLLECTION**



To The Applicant: Return Completed Form to:  
Public Works Department  
84 S. Main St.  
Cheshire CT 06410

**PLEASE NOTE: PAGE 3 MUST BE COMPLETED BY YOUR HEALTH CARE PROVIDER.**

**NOTE:** Once this application has been approved and processed, your trash/garbage pick-up will be collected weekly on your usual pick-up day. Your green recycle container will be picked up on every other TUESDAY (town-wide).

Leave your trash and recycle containers by the garage or other convenient location the night before. The haulers will come up your driveway, empty the containers, and return them to your designated location.

**“PHYSICALLY DISABLED” DEFINED**

**A PERSON WILL BE DEEMED “PHYSICALLY DISABLED” FOR THE PURPOSES OF THIS PROGRAM, IF SHE/HE SUFFERS ONE OR MORE OF THE FOLLOWING PHYSICAL IMPAIRMENTS:**

**BLINDNESS:** If the person has a central visual acuity of 20/200 or less in the better eye with the use of a correcting lens, an eye which is accompanied by limitation in the field of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered as having central visual acuity of 20/200 or less.

**OTHER:** If the person has a chronic physical handicap, infirmity, or impairment, whether congenital or resulting from bodily injury, organic process or changes, or from illness, including but not limited to epilepsy, cerebral palsy or reliance on a wheel chair or other remedial appliance or device.

**The determination of whether a person/s is “physically disabled” within the meaning of the foregoing definition will be made by the department of public works or its designee on the basis of submitted evidence. The opinion of a physician in the form prescribed by the department of public works may be essential to the determination of eligibility for rear yard collection. The applicant must arrange for the physician’s services at his/her own expense. The department of public works or its designee, reserves the right to require proof of impairment in addition to the physician’s opinion.**

**NON-CURBSIDE COLLECTION APPLICATION**  
**CERTIFICATION OF ELIGIBILITY – PAGE 2**

**PLEASE PRINT**

My usual trash collection day is \_\_\_\_\_

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**Address NUMBER AND STREET NAME**

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**Name LAST**

**FIRST**

**MIDDLE INITIAL**

**DATE OF BIRTH** \_\_\_\_\_

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**Mailing address (if different)**

**NUMBER AND STREET**

**CITY**

**ZIP CODE**

**TELEPHONE NUMBER (        )** \_\_\_\_\_

\_\_\_\_\_ I am “physically disabled” as defined within this application

I certify this statement and affix my signature:

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Signature of Resident

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Date

**TOWN OF CHESHIRE, CONNECTICUT**  
**NON-CURBSIDE COLLECTION APPLICATION**  
**CERTIFICATION OF ELIGIBILITY- PAGE 3**



**DISABILITY FORM (required for applicants under age 70)**

**PLEASE NOTE: FORM MUST BE COMPLETED BY YOUR HEALTH CARE PROVIDER.**

**PLEASE PRINT CLEARLY**

Applicant's name: \_\_\_\_\_

Applicant's address: \_\_\_\_\_

Type of disability: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician of record:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, state, zip code: \_\_\_\_\_

Telephone number: \_\_\_\_\_

DOCUMENTATION SUBMITTED: