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

To The Applicant: Please return completed form to:
Public Works Department
84 S. Main St.
Cheshire CT 06410

Additional members of your household must sign statements on page 2-3 certifying their age (over 70) or their disability.

For disability application, please return page 4, completed by your health care provider.

PLEASE PRINT **My usual trash collection day is _____**

_____

NUMBER AND STREET NAME

OWNER'S NAME

_____

LAST NAME **FIRST** **MIDDLE INITIAL**

MAILING ADDRESS (if different)

_____

NUMBER AND STREET **CITY** **ZIP CODE**

TELEPHONE NUMBER

( ) _____

--OVER--

NON-CURBSIDE COLLECTION APPLICATION
CERTIFICATION OF ELIGIBILITY – PAGE 2

RESIDENT #1

Name:_____ Social Security # _____

☐ i am over seventy (70) years of age and **am providing proof of age**

I certify this statement and affix my signature:

_____ _____
Signature of Resident #1 Date

RESIDENT #2

Name:_____ Social Security # _____

☐ i am over seventy (70) years of age and **am providing proof of age**

I certify this statement and affix my signature:

_____ _____
Signature of Resident #2 Date

RESIDENT #3

Name:_____ Social Security # _____

☐ i am over seventy (70) years of age and **am providing proof of age**

I certify this statement and affix my signature:

_____ _____
Signature of Resident #3 Date

NON-CURBSIDE COLLECTION APPLICATION
CERTIFICATION OF ELIGIBILITY – PAGE 3

PLEASE NOTE: PAGE 4 MUST BE COMPLETED BY YOUR HEALTH CARE PROVIDER.

"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.

CERTIFICATION OF ELIGIBILITY

RESIDENT #D1

Name:_____ Social Security # _____

_____ i am "physically disabled" as defined within this application

I certify this statement and affix my signature:

_____ _____
Signature of Resident #D1 Date

--OVER--

TOWN OF CHESHIRE, CONNECTICUT
NON-CURBSIDE COLLECTION APPLICATION
CERTIFICATION OF ELIGIBILITY- PAGE 4

DISABILITY FORM (required for applicants under age 70)
TO BE COMPLETED BY PHYSICIAN

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

PLEASE PRINT CLEARLY

Applicant's name: _____

Applicant's address: _____

Type of disability: _____

Physician of record:

Name: _____

Address: _____

City, state, zip code: _____

Telephone number: _____

DOCUMENTATION SUBMITTED: