

VERIFICATION FOR CURBSIDE ASSISTANCE

This Verification for Curbside Assistance is for providing special services to residents who are disabled or physically unable to place their refuse containers at the designated point of collection and/or are unable to shovel snow out of their driveway approach. The City of Akron is able to provide these special assistive services on a limited basis to those whose mobility is medically and physically impaired and there is no able-bodied person in the household who can move the containers. This assistance is for up to one trash container and one recycle container per trash pick-up day. In order to be eligible for this special service, the container(s) must not be located inside of a fence or enclosure of any kind.

Residents requesting these services must complete the Request for Service Information section on this form and have their health care provider complete and sign the Medical Certification for Curbside Assistance section prior to receiving these services. The City will not begin the Curbside Assistance services until it has received the completed form. **The City may discontinue this service at any time.**

REQUEST FOR SERVICE INFORMATION

(To Be Completed By the Resident)

RESIDENT'S NAME: _____ TODAY'S DATE: _____

SERVICE ADDRESS: _____ ZIP CODE: _____

PHONE NUMBER: _____ BEST TIME OF DAY TO CALL: _____

I am requesting the following services and verify that I do not have an able-bodied person in my household who can perform the service(s):

- SNOW REMOVAL FROM DRIVEWAY APPROACH TRASH COLLECTION RECYCLE COLLECTION
- Permanent request Temporary request through _____ (date)

I hereby give consent to my health care provider to provide the certification set forth below to the City of Akron Service Department. I understand that I may be required to update this information if there is a change in my circumstances or at the request of the City of Akron. I understand that trash and recycle collection service may not be available in inclement weather. I also understand that the services listed on this form may be discontinued at any time.

Resident's Name _____

Resident's Signature _____

MEDICAL CERTIFICATION FOR CURBSIDE ASSISTANCE

Medical certification is required to verify the need of each resident who requests curbside assistance. Please fill out this section on behalf of your patient who is currently requesting these services. Your cooperation in this matter is greatly appreciated.

I hereby certify that _____ is under my care and is not able to place their refuse containers at the designated point of collection and/or is unable to shovel snow from their driveway approach.

Indicate below the service(s) the individual is unable to perform:

- Snow Removal from Driveway Approach Trash / Recycle Receptacle Curbside Placement

Permanent request Temporary request through _____ (date)

Physician's Name (print)

Physician's Signature

Date _____

WHEN COMPLETED BY RESIDENT AND CERTIFIED BY PHYSICIAN, SEND TO:

**Bureau of Public Works, Sanitation Division
1436 Triplett Boulevard, Akron, OH 44306**

***If you need assistance with more than one of each type of container per week, please call 330-375-2831 for assistance.**