A TRADITION of SERVICE Since 1939
Pellitteri WASTE SYSTEMS
7035 RAYWOOD ROAD
P.O. BOX 259426
MADISON, WI 53725
P: 608.257.4285 | F: 608.257.1179
PELLITTERI.COM

Automated Waste Disposal & Recycling Collection Program:
Assistance for the Disabled

In order to assist persons with disabilities who do not have anyone to help them with their chores, Pellitteri Waste Systems has set up a program to help these residents get the recycling and waste collected.

Qualified residents will have their carts wheeled from outside their home to the curb and then back to their home by our service technicians/drivers.

To qualify for the Residential Disabled Roll-Out Service residents must:

1) Be unable to wheel their cart(s) to the curb for collection.

2) Have no one else who can assist them such as a spouse or other live-in family member or a personal assistant.

3) Be certified by a physician as needing assistance.

4) Fill out and return the required Residential Disabled Roll-Out Service Application.

Participation Guidelines:

1) On collection day your carts must be placed where they can be seen from the street.

2) In winter, a path must be clear of snow and ice so our staff can get the carts to the street and back.

Please return by mail to:

Pellitteri Waste Systems
Attn: Residential Division
P.O. Box 259426
Madison, WI 53725-9426

You will be notified by phone after your application has been received and further instructions will be given at that time.

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Residential Disabled Roll Out Service Application

Applicant Information

Name: _____

Residential Address: _____

City: _____Zip Code: _____

Phone Number: _____Email: _____

Applicant's Verification of Disability and Household Occupancy

I, the undersigned applicant, certify that I am _____ temporarily _____ permanently disabled and unable to push my recycling/refuse cart to the curb. I also certify that there is no one in my household, in my employ, or providing in home assistance to me from a third party that is able to get my carts to the curb. I understand that I may be required to re-submit this form annually from this date for continuance of this residential disabled roll out service. I authorize my physician or optometrist to release any information necessary to verify my disability.

Signature of Applicant: _____Date:_____

Disability Statement

To be completed by a Licensed Physician (or Optometrist if Applicant is legally blind)

I, a licensed physician or optometrist, hereby certifies that _____ is currently disabled as described below and unable to get his/her recycling/refuse carts to the curb.

I further certify that this disability is _____ temporary in nature.
(Length of disability is from _____ to _____)
-Or-
I further certify that this disability is _____ permanent nature continuing for the applicant's lifetime.

Name of Physician or Optometrist: _____

Address: _____

City: _____Zip Code: _____

Phone Number: _____

Signature: _____Date:_____