Consolidated Disposal
12949 Telegraph Road
Santa Fe Springs, CA 90670
Phone: (562) 347-2100

CR&R
12739 Lakeland Road
Santa Fe Springs, CA 90670
Phone: (562) 944-4716

Reduced Rates for Disposal Fees
For Low-Income Disabled Residents

The criteria for qualification for reduced trash collection rates for Norwalk residents is as follows:

1. Total monthly gross income for **ALL** occupants of the residence shall not exceed the income level set by the City. This limit is reviewed and adjusted annually.

   All sources of income shall be included in determining the monthly gross income, including, but not limited to, salary and wages, interest and rental income, pension and Social Security, State Supplemental Income and Worker's Compensation.

2. In addition to meeting the income restrictions set forth in paragraph 1, the head of household must be disabled for a period of not less than three (3) months. Such disability shall be certified by the resident's physician on Physician Form – Disabled Certification. (See Page 3)

3. The disabled occupant must either be the registered homeowner or be paying for the trash bill if renting.

4. This discounted rate allows only for 1 black, 1 green and 1 blue container.

5. Return completed form to the disposal company that services your address. Addresses for disposal companies are located at the top of this form.

6. Please contact your disposal company for questions regarding this application.

APPLICATION FORM ON PAGE 2
PHYSICIAN FORM – DISABLED CERTIFICATION ON PAGE 3

REDUCED DISPOSAL FEES APPLICATION FORM

Service Address:		Norwalk, CA 90650
Phone Number:		
Do you rent or own your residence? ☐ Rent ☐ Own		
	Name	Monthly Gross Income
Applicant:		
Spouse:		
Others Residing At Address:		
		_____
Total Monthly Gross Income for all Persons Residing at Address:		
Total Number Residing at Address:		

I understand that this application shall not be approved if: 1) an unpaid balance for trash collection service is due and owing on account; 2) adequate information or supporting data as required was not provided; and/or 3) misstatements or misrepresentations with respect to the qualifications were made.

This application, upon approval, shall remain valid for one (1) year and must be renewed on an annual basis. Any misrepresentations found during the year will cause the discount to be discontinued.

I hereby declare under penalty of perjury that all information submitted with this application is true and correct to the best of my knowledge. Further, I agree to provide additional information or documentation deemed appropriate or necessary to verify the information contained in the application.

_____ _____

Applicant's Signature Date

Approval: Approved ☐ Denied ☐	By: _____	Date: _____

Physician Form
Disabled Certification
Reduced Rates for Disposal Fees

Applicant's Name:	
Address:	
Physician's Name:	
Physician's Address:	
Physician's Telephone:	
State License Number:	

The dysfunction is due to the following disability: (Choose all applicable sections)

☐ Visual impairment such that, after best correction, vision in the better eye is not capable of distinguishing shapes to the extent that it would be severe hardship for a person to have to walk or negotiate steps.

☐ Cardio–vascular impairment resulting in marked limitation of physical activity. Less than ordinary physical activity causes fatigue, palpitation or anginal pain. Ordinary physical activity should be marked restricted.

☐ Severe respiratory impairment in which shortness of breath does not appear during times of rest but does occur during ordinary daily activities such as stair climbing. At the time of upper respiratory illness, it may become severe enough to require hospitalization.

☐ Inability to walk a distance of twenty (20) yards and/or negotiate steps because of musculoskeletal impairment, such as muscular dystrophy, osteogenesis imperfecta, or severe rheumatism or arthritis.

☐ Amputation of, or anatomical deformity (due to vascular or neurological deficits, or x-ray evidence of body or fibrous ankylosis) or instability of:
- ☐ Both Hands
- ☐ One hand and one foot
- ☐ One lower extremity at or above tarsal region

☐ Neurological disorder due to brain dysfunction or damage to the central nervous system including cerebral palsy resulting in aberration of motor function.

☐ Paralysis, incoordination, or functional motor deficit in any two limbs due to brain, spinal or peripheral nerve injury, including paraplegia, quadriplegia, hemiplegia, etc.

☐ Epilepsy (convulsion disorder) involving impairment of consciousness that occur more frequently than once a month despite prescribed treatment.

☐ Other: (Specify medical disorder and resultant restrictions of mobility.)

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Certification:

I hereby certify that I am a licensed physician of the State of California and have knowledge of the above applicant. I have completed this application by checking all applicable disabilities and recommend that the City of Norwalk issue the Reduced Rates for Disposal Fees to the applicant on the following basis:

☐ Temporary disability (minimum of three months)

Estimated period of disability _____

☐ Permanent disability

_____ _____

Physician's Signature Date