BY-LAW NO. 2020-14
SCHEDULE "A"

Application for Service Level Change

I hereby declare that I have a disability that is sufficiently severe such that I am unable without assistance to set out, and bring back in after collection has occurred, my garbage and recycling carts some or all of the time and I do not have an able-bodied person that can perform the function. I consent to the disclosure of personal information (including medical information) by a medical professional to the RM of West St. Paul for the purposes of determining my eligibility for the Set Out/Set Back service. I will advise the RM of West St. Paul or its agents of any changes to my mobility needs. I understand that the RM of West St. Paul has the right to review my application from time to time and can revoke my registration if they determine that I am no longer eligible for the service.
Set Out / Set Back Service shall include collection crews entering my property parcel to move Garbage and Recycling collection carts to the curb or lane allowance for collection and return them to the property after the passage of collection.

I, ______________________ as occupier of property located at ______________________ hereby apply for this service and agreeto the following conditions:

- The occupier of this property has a physical disability that prevents them from moving the carts to the collection point and do not have an able-bodied person to help them with this activity;
- Carts shall be freely accessible and not be placed inside closed buildings or a gated area;
- If an able-bodied person becomes available prior to the expiry of an approval, this service will no longer be provided;
- The Municipality is not responsible for any damage to private property resulting from the executing of this service.
- Approval of this service is at the discretion of the RM of West St. Paul

Applicants Information

What is the nature of the disability? ____

Name of medical professional ______________________ Telephone: ________________

Is the disability permanent?________

If the disability is not permanent, at what date would the Applicant be sufficiently recovered? __________________

______________________ ______________________ ______________________
Signature of Applicant Phone Number Date

Please identify the area that the garbage and recycling carts will be located on collection days: ____________

____

Office use only

☐ application is approved ☐ application is denied

Physician's Certificate Required (Schedule “B” to be completed and returned to the Municipality)

The occupier will assist with any special designations as may be required to alert the crews that this type of collection is required; and comply with the following: ____

____

BY-LAW NO. 2020-14
SCHEDULE "B"

Supplemental Form for Persons with a Disability

This form is provided to Physicians in order to verify that the person named herein has a physical limitation that would prevent the person from setting out wheeled garbage/recycling carts for collection at the location specified by the Rm of West St. Paul.

All information collected is under the authority of the Manitoba Personal Health Information Act (PHIA) and is protected by the Protection of Privacy provisions of PHIA and FIPPA (The Freedom of information and Protection of Privacy Act) All information provided in this form is confidential and solely for the use of the RM of West St. Paul in determining eligibility for Set Out/Set Back service as authorized by the RM of West St. Paul.

I authorize the professional completing this form to release pertinent medical information to the RM of West St. Paul about my disability or health condition as it relates to determining eligibility for this specialized service.

Patients Name: ____

Address: ____ ________________
(Street Number and Name) (Postal Code)

What is the nature of the disability? ____

Is the disability permanent? ______________________________
If the disability is not permanent, at what date would the patient be sufficiently recovered? ________________

Physician's Signature: ____ Telephone: ________________

Physician's Name: ____

☐ Physician ☐ Physical therapist ☐ Certified Psychologist/Psychiatrist

☐ Chiropractor ☐ Occupational Therapist ☐ Optometrist/Ophthalmologist

☐ Registered Nurse ☐ Long Term Care Case Manager

Date: ________________ 20_______

Advocate or Spokesperson Completing Form for Applicant

☐ I certify that the information provided in this application is true and correct, based upon information given to me by the applicant.

☐ I certify that the information provided in this application is true and correct, based upon a designated service agency assessment of the applicant's health condition or disability, which restricts their ability to manage this function.

______________________________ ______________________________
Name Signature

______________________________ ______________________________
Facility or Program Relationship to Applicant

______________________________ ______________________________
Address Daytime Phone Number

________________ ________________ ______________________________
Date Received Date Approved RM of West St. Paul