City of Dallas

Department of Sanitation Services
Helping Hands Program Application

Instructions: Review the Helping Hands Program Requirements prior to completing this form. Participation in the Helping Hands Program is subject to submission of complete and accurate information, including this Application and a Declaration of Special Need form. Applicants must renew every two (2) years to maintain eligibility.

INTENTIONAL MISREPRESENTATION IN THIS DOCUMENT IS A MISDIMENOR PUNISHABLE BY A FINE NOT TO EXCEED $500 PURSUANT TO SECTION 18-9 OF THE DALLAS CITY CODE

Please Check One: ☐ **Initial Application** ☐ **Renewal**

PLEASE PRINT RESPONSES

APPLICATANT NAME		
FIRST	**MIDDLE**	**LAST**

RESIDENTIAL SERVICE ADDRESS			
Street Address:			
Street Address (cont.):			
City, State:	**DALLAS, TEXAS**	**ZIP:**	
Phone:		**Email:**	
Water Account No.:			

APPLICANT'S CERTIFICATION – To be completed by Applicant or their legal guardian or attorney-in-fact

I, the undersigned Applicant, have received the Helping Hands Program Requirements and I meet the Helping Hands Program eligibility requirements. I authorize my Licensed Medical Professional to disclose the existence of a permanent or temporary disability. I understand that it is my responsibility to re-submit this Application and Declaration of Special Need form every two years from the date of acceptance by the City of Dallas for the continuance of residential sanitation collection assistance.

Applicant Signature:		**Date:**	

Applicant/Legal Guardian/Attorney-In-Fact

DISABILITY CERTIFICATION (Not required for renewals related to previously certified permanent disabilities)

To be completed by a Licensed Medical Professional - A Licensed Medical Professional is a physician, podiatrist, optometrist, or qualifying physician's assistant or advanced practice nurse as defined in Chapter 301, Texas Occupations Code.

I, the undersigned Licensed Medical Professional, certify that the applicant named above has a disability as defined in the Helping Hands Program Requirements.

Nature of Disability: ☐ Permanent ☐ Temporary (Estimated Length of Disability is from _____ to _____)

Licensed Medical Prof. Name:		**License No.:**	
Business Address:			
Business Address (cont.):		**City/State:**	
Business Phone:		**ZIP:**	
Signature of Licensed Medical Professional:		**Date:**	

FOR SANITATION BILLING USE ONLY			
Sanitation Billing has reviewed the Application and Declaration for the above-named residential service address and hereby determines:			
START DATE:		END DATE:	
SAN EMPLOYEE NAME:		DATE:	