Dear Resident(s):

Thank you for contacting the Division of Refuse Collection regarding Exemption Service. This service is to provide residents who are medically disabled or physically unable to dispose of their refuse, and do not have a family member or neighbor who can assist them.

To apply for Exemption Service, please complete the enclosed questionnaire form and sign the consent to release information on the medical documentation form. Your physician must complete the bottom portion of the medical documentation form in its entirety; just a signature will not qualify for this service. This information remains confidential and is only used in determining your eligibility for Exemption Service. Please return both forms to the Division of Refuse Collection in the pre-addressed return envelope.

All members of your household must complete a medical documentation form in order for the residence to be approved for exemption service. If additional forms are needed, please contact the 311 Service Center to have copies mailed to you.

You will be notified in writing within fifteen (15) working days upon receipt of the forms, to inform you if your application was approved.

Sincerely,

Michael Pickard
Operations Manager
Division of Refuse Collection

MAP: mab
MEDICAL DOCUMENTATION FOR EXEMPTION SERVICE

The Division of Refuse Collection provides a special service to residents who are disabled or physically unable to place their refuse at the designated point of collection. Your patient has requested this service.

Many residents inform us they are physically unable to lift or carry a refuse container or bag to the curb or alley line, or they are unable to use the 300- or 90-gallon container placed in their area. In addition, they do not have any available relative, friend or neighbor who can perform this task for them. While we are happy to provide this service, we must limit its availability to those whose mobility is medically and physically impaired.

We request that medical documentation be provided to verify the need of each resident who receives exemption service. Please fill out the lower portion of this letter, in its entirety, on behalf of your patient who has applied to receive this service. Your cooperation in this matter is greatly appreciated.

Sincerely,

Mail to:
Michael Pickard
Operations Manager
Division of Refuse Collection
Exemption Service
2100 Alum Creek Drive
Columbus, OH 43207

I hereby give consent to my physician to release information to the Division of Refuse Collection about my condition.

Print Resident's Name: ___________________________  ___________________________  Resident's Signature
Address: ___________________________
Zip Code (only): ___________ (city & state not necessary)  ___________________________  E-mail Address

Doctor's Certification for Exemption Service

(must be completely filled out by the doctor, just a signature will not qualify for exemption service)

I hereby certify that ___________________________ is under my care for the treatment of ___________________________

____________________________  ______________________________
Print Physician's Name or Add Stamp  Physician's Signature  Date

____________________________
which impairs mobility and physically restricts the patient from placing their refuse at the designated point of collection.
DIVISION OF REFUSE COLLECTION
EXEMPTION SERVICE QUESTIONNAIRE
(To be completed by the resident. Please answer ALL the questions)

NAME: Mr./Mrs./Ms./Miss ________________________________ (circle one)

CURRENT ADDRESS: ____________________________________________

ZIP: ________ NEAREST CROSS STREET: _______________________________________

PHONE NUMBER: ___________________________ BEST TIME OF DAY TO CALL: _________

RESIDENT’S AGE: _______ NUMBER LIVING IN HOUSEHOLD: ________________

AGE(S) OF ALL ADDITIONAL PERSON(S) LIVING IN HOUSEHOLD: __________________

ADDITIONAL RESIDENT NAME: Mr./Mrs./Ms./Miss ________________________________

ADDITIONAL RESIDENT NAME: Mr./Mrs./Ms./Miss ________________________________ (circle one)

ADDITIONAL RESIDENT NAME: Mr./Mrs./Ms./Miss ________________________________ (circle one)

TYPE OF SERVICE BEING REQUESTED: REFUSE ONLY [ ] or REFUSE & RECYCLING [ ]

TYPE OF CITY COLLECTION SERVICE USED IN YOUR AREA:

96-GALLON CONTAINER (Curb Collection) [ ] or 300-GALLON CONTAINER (Alley Collection) [ ]

DO YOU HAVE A FRIEND, NEIGHBOR, OR RELATIVE WHO IS WILLING TO PLACE YOUR REFUSE AT
THE DESIGNATED POINT OF COLLECTION? YES _______ NO _______

WHO CURRENTLY PLACES YOUR REFUSE OUT FOR COLLECTION? __________________________

ARE YOU CURRENTLY UNDER A PHYSICIAN’S CARE FOR A CHRONIC ILLNESS THAT IMPAIRS
YOUR MOBILITY? YES _______ NO _______

DO YOU NEED THE ASSISTANCE OF AN AID IN YOUR MOBILITY? NO _______ YES _______

IF YES, WHAT TYPE: WHEELCHAIR ______ WALKER _______ CANE ______

REASON FOR REQUESTING EXEMPTION SERVICE & INFORMATION REGARDING OTHERS LIVING IN
HOUSEHOLD: ________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

TODAY’S DATE: __________________________

PLEASE ATTACH THE MEDICAL CERTIFICATION FORM and return to:

Division of Refuse Collection
Exemption Service
2100 Alum Creek Drive
Columbus, OH 43207