JENNIFER GALLAGHER
Director

THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR

DEPARTMENT OF
PUBLIC SERVICE

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 recycling, 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.

Sincerely,

Catrina Whitlock

Catrina Whitlock
Operations Manager
Division of Refuse Collection

CW: kr

JENNIFER GALLAGHER
Director

THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR

DEPARTMENT OF
PUBLIC SERVICE

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,

Catrina Whitlock

Catrina Whitlock
Operations Manager
Division of Refuse Collection

Mail to:
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: _____ _____
E-mail Address

Zip Code (**only**): _____ (city & state not necessary)

Doctor's Certification for Exemption Service

(Must be completely filled out and signed by physician)

I hereby certify that _____ (please print patient's name) is under my care for a medical condition which impairs mobility and prevents my patient from placing their refuse or recycling containers at the standard point of collection. (Below, please initial the appropriate condition).

_____ I believe my patient's condition is permanent.

_____ I estimate my patient's temporary condition will last until _____/_____/_____.

_____ _____ _____
Print Physician's Name or Add Stamp | Physician's Signature | Date

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Director

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DEPARTMENT OF
PUBLIC SERVICE

Additional Household Member

MEDICAL DOCUMENTATION FOR EXEMPTION SERVICE

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Sincerely,

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

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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 and signed by physician)

I hereby certify that _____ (please print patient's name) is under my care for a medical condition which impairs mobility and prevents my patient from placing their refuse or recycling containers at the standard point of collection. (Below, please initial the appropriate condition).

_____ I believe my patient's condition is permanent.

_____ I estimate my patient's temporary condition will last until _____/_____/_____.

_____ _____ _____
Print Physician's Name or Add Stamp | Physician's Signature | Date

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 _____
(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 CURENTLY 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: _____

return to:

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