

Dear Resident:

Thank you for contacting the Division of Refuse Collection regarding Exemption Service. This service is provided to 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. This information remains confidential and is used only 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

Enclosure: 2



DIVISION OF REFUSE COLLECTION  
**EXEMPTION SERVICE QUESTIONNAIRE**  
(To be completed by the resident. Please answer all questions)

NAME: \_\_\_\_\_

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: \_\_\_\_\_

TYPE OF SERVICE BEING REQUESTED: REFUSE ONLY \_\_\_\_\_ REFUSE & RECYCLING \_\_\_\_\_

TYPE OF CITY COLLECTION SERVICE USED IN YOUR AREA:

96-GALLON CONTAINER \_\_\_\_\_

300-GALLON CONTAINER (Alley Collection) \_\_\_\_\_

WHO CURRENTLY PLACES YOUR REFUSE OUT FOR COLLECTION? \_\_\_\_\_

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE FOR A CHRONIC ILLNESS  
WHICH IMPAIRS MOBILITY? YES \_\_\_\_\_ NO \_\_\_\_\_

DO YOU NEED THE ASSISTANCE OF AN AID IN YOUR MOBILITY? IF YES,  
WHAT TYPE: WHEELCHAIR \_\_\_\_\_ WALKER \_\_\_\_\_ CANE \_\_\_\_\_

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

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

**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 on behalf of your patient who has applied to receive this service. Your cooperation in this matter is greatly appreciated.

Sincerely,



Michael Pickard  
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: \_\_\_\_\_

Zip Code (only): \_\_\_\_\_ (city & state not necessary)

\_\_\_\_\_  
E-mail Address

**Doctor's Certification for Exemption Service (must be filled out by the doctor)**

I hereby certify that \_\_\_\_\_ is under my care for the treatment of  
PRINT PATIENT'S NAME

\_\_\_\_\_ which impairs mobility and physically restricts the patient from placing their refuse at the designated point of collection.

\_\_\_\_\_  
Print Physician's Name or Add Stamp

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

