SACRAMENTO COUNTY

County of Sacramento
Public Works & Infrastructure
Department of Waste Management & Recycling

Doug Sloan, Director

OCTOBER 14, 2020

JOE PUBLIC
0000 ELKPOINT ST
SACRAMENTO CA 99999-0000

Dear Customer,

You have requested a Disability Exemption service for your garbage, mixed recycling and green waste carts. Applications for Disability Exemption shall comply with each of the following standards, terms, and conditions:

- The applicant must be the principal occupant.
- The applicant must be disabled, precluding them from moving wheeled carts to the curbside for service due to physical impairment that is permanent or temporary.
- The applicant shall certify that no other person residing with them is physically able to move wheeled carts to the curbside for service.
- The applicant shall provide a doctor's statement verifying a medical condition that precludes them from moving wheeled carts to the curbside for service.
- The applicant can place wheeled carts no more than 125 feet from the street. The cart path to the street must be a hard (solid) surface.
- Any pets on the property will be kept under control whenever the County is servicing the carts

Proof of qualification for a Disability Exemption may be made by completing this application form, and mail, email or fax to:

County of Sacramento
Consolidated Utilities and Billing Service
9700 Goethe Road, Suite C
Sacramento, CA 95827
Email: utilities@saccounty.net
Fax: (916) 854-9292

You will receive written verification regarding your eligibility status. If you have questions regarding your qualification or eligibility status, please call 916-875-5555; TDD (hearing impaired) 916-875-7105, Monday - Friday / 8:00 a.m. - 4:30 p.m.

Disability Exemption status is subject to periodic evaluation. The County may require persons granted this service to provide subsequent verification of eligibility upon request. It is the responsibility of a disabled customer to notify the County of any change that would void the exemption status, such as:

- An able bodied person now resides that was not present at the time of the original request, or
- A physical condition has now improved in an existing resident.

If a Disability Exemption service is provided and the above conditions are not met, or the result of a field audit reveals that an able-bodied person resides in the household, an applicable service charge will be assessed and exemption status revoked.

Sincerely,

Doug Sloan, Director
Department of Waste Management & Recycling

COUNTY OF SACRAMENTO
PUBLIC WORKS & INFRASTRUCTURE
DEPARTMENT OF WASTE MANAGEMENT & RECYCLING
DISABILITY EXEMPTION REQUEST FORM

Account #: Premise #: APN:

Name (Please Print): _____

Phone # _____

Address & Zip Code: _____

I have read the County of Sacramento Disability Exemption standards, terms, and conditions and understand exemption status may not be permanent, and that periodic evaluation may occur annually or at any other time deemed necessary by the County. I confirm that I will comply with each of following:

- o I am the principal occupant of this residence and am physically unable to move wheeled carts to the curbside for service.
- o No other occupant at this residence is physically able to move wheeled carts to the curbside for service.
- o I can place the wheeled carts no more than 125 feet from the street.
- o The container path to the street is a hard (solid) surface.
- o Any pets on my property will be kept under control whenever the County is servicing the carts
- o I certify that my answers to these questions are true and correct.

Applicant's Signature:_____ Date: _____

Generally, exemptions granted are valid for three (3) years as long as the ownership status and other conditions on the application remain unchanged. You will receive a renewal letter and application at the 3-year mark.

PHYSICIAN STATEMENT

Name of Physician (Please Print) Medical License # Phone #

Mailing Address & Zip Code: _____

I certify that above named applicant is physically unable to move the wheeled containers in question to the curbside for service.

Permanent Disability _____

Temporary Disability _____

Date Temporary Disability will end _____

Physician Signature: _____

Date: _____

FOR OFFICIAL USE ONLY:

Approved _____

Disapproved _____

Date _____

Name:_____ Signature: _____