CARROLL COUNTY COMMISSIONERS

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Commissioners
*Jeffrey L. Ohler * Thomas R. White * Robert E. Wirkner*

CARROLL COUNTY - 2016 HOME SEWAGE TREATMENT SYSTEM (HSTS) ASSISTANCE PROGRAM: OWNER APPLICATION

This application will be used to evaluate your eligibility for home sewage treatment system repair or replacement. The Carroll County Health Department, in conjunction with the Carroll County Commissioners' Office, is administering this program which is funded through the Ohio Water Pollution Control Loan Fund (WPCLF) from the Ohio Environmental Protection Agency. Completing this form does not commit or obligate you in any way and does not guarantee funding for your sewer repair or replacement. All information on and accompanying this form will be kept strictly confidential.

Criteria for Qualification:

A. Income

Annual income must be below those listed in the table below. If annual income is at or below those listed in Column A, 100% of the project costs will be paid. If annual income is at or below those listed in Column B, 85% of the project costs will be paid. If annual income is at or below those listed in Column C, 50% of the project costs will be paid.

Project costs not covered by the program and any percentage owed by the homeowner must be paid in full at least 14 days prior to start of any work.

	COLUMN A	COLUMN B	COLUMN C
# of people in home	100% of project costs paid if annual income at or below:	85% of project costs paid if annual income at or below:	50% of project costs paid if annual income at or below:
1-4	$24,250	$48,500	$72,750
5	$28,410	$56,820	$85,230
6	$32,570	$65,140	$97,710
7	$36,730	$73,460	$110,190
8	$40,890	$81,780	$122,670

B. Occupancy & Property Taxes

Applicants must be the homeowner and occupy the dwelling as their primary residence and be current on their property taxes. The property must be located in Carroll County.

C. Nature of the Septic Repair

The dwelling must be in need of a septic repair/replacement. The nature of the required repair/replacement must serve to protect the health and/or safety of the household and the public.

APPLICANTS MUST SUBMIT THE FOLLOWING VERIFICATION DOCUMENTS:

HOME OWNERSHIP VERIFICATION

- □ Copy of the property deed in their name(s) – can be obtained from the Recorder's office
- □ Copy of the title to the home, if applicable (for example, for trailers)
- □ Copy of paid property taxes – can be obtained from the Treasurer's office

INCOME VERIFICATION

- □ Copy of 2016 income tax returns, including W-9, 1099 or similar form
- □ Income verification from 1/1/2017 to current, including any of the following which apply to you:
  - □ Paystubs
  - □ Social security award letter
  - □ Retirement benefits
  - □ Disability benefits
  - □ Public (cash) assistance
  - □ Alimony
  - □ SSI supplemental security income
  - □ Child support
  - □ Unemployment benefits
  - □ Workers compensation benefits
  - □ Profit/loss statement for home based businesses, ebay, craigs list, avon, etc.
  - □ Profit loss statements for those who are self employed
- □ If no income, provide the following:
  - □ A letter dated and signed by the person providing help or funding to you stating what bills they are paying, the amount of each bill, over what time period they have paid, and how long they plan on continuing to help you
- □ Past 2 months bank statements from checking and savings
- □ 401K statements, annuities, interest bearing account statements
- □ Food stamps award letter

ADDITIONAL INFORMATION:

- Priority will be extended in an emergency situation to eliminate immediate health and safety hazards.
- Grants will be provided to qualified households. No mortgages, deed restrictions or paybacks of any type will be required.
- Application for the WPCLF 2016 Grant will be accepted through the duration of the grant period and assistance will be provided on first-come-first-serve basis to qualified households.
- Several sites may be bundled into one contract for bidding. The contractor with the most acceptable bid will be awarded the contract. The homeowner does not choose the contractor for the replacement/repair.
- Homeowner must allow the local Health Department, EPA representatives and contractors to enter upon the property to make inspections.
- The installation of a sewage treatment system will create a messy environment. Since soil takes time to settle, final grading may not take place for several months after the repair/installation work is completed.
- The Health Department is required to inspect all sewage treatment systems that are altered/installed 12 months after approval then again every 10 years.
- Before any work can begin, permits must be obtained by the contractor from the Health Department.
- For those who are 85% or 50% eligible, the remaining funds (15% and 50%) must be paid in full at least 14 days ***before*** work can commence.

I. APPLICANT INFORMATION:

Applicant First Name	Last Name	Social Security #
Co-Applicant First Name	Last Name	Social Security #
Street Address		
City	State	Zip Code
Phone #	Alt. Phone	Date of Birth
E-mail Address:		
How many people live on the property? _____		
Marital Status: _____ Married _____Separated _____ Unmarried _____ Divorced _____ Widowed		
Are you the owner and occupant of the property? _____ Yes _____No		
How long have you lived here: _____	Number of Bedrooms: _____	
Do you plan to sell the property within the next five years? _____ Yes _____No		

II. APPLICANT & CO-APPLICANT EMPLOYMENT DATA:

Applicant

Employer Name:	Occupation:
Employer Address:	
Length of Employment:	Annual Salary (Gross): $
Hourly Wage Amount: $	Monthly Tips Received: $
Other Wages (please list source & amount):	

Co-Applicant

Employer Name:	Occupation:
Employer Address:	
Length of Employment:	Annual Salary (Gross): $
Hourly Wage Amount: $	Monthly Tips Received: $
Other Wages (please list source & amount):	

III. HOUSEHOLD MEMBERS

Including both applicant and co-applicant, please list the names, relationship, date of birth, and gross income of everyone living on the property. Please submit supporting documentation as listed on page 2 for those over the age of 18 currently occupying the property. Additional names may be listed on a separate sheet.

Name	Relationship to Applicant	SSN #	Date of Birth	Income Source	Total Income for Last 12 Months

IV. CERTIFICATION

PLEASE READ THE FOLLOWING STATEMENTS. IF YOU DO NOT UNDERSTAND ANY PART OF THIS APPLICATION OR HAVE A QUESTION ABOUT WHAT YOU ARE BEING ASKED TO SIGN, PLEASE ASK SOMEONE AT THE HEALTH DEPARTMENT OR COMMISSIONERS' OFFICE TO HELP YOU. BY SIGNING BELOW YOU ACKNOWLEDGE YOUR UNDERSTANDING OF THE APPLICATION AND VERIFICATIONS.

I certify that the information I have provided in this application is, to the best of my knowledge, a true, accurate, and complete disclosure of the requested information. I understand that I may be held civilly and criminally liable under Federal and State law for knowingly making false or fraudulent statements. I further certify I am not an employee, family member, agent or official exercising any functions or responsibilities in connection with the review or approval of the work completed under the WPCLF 2016 program.

I understand that if I am eligible to receive 85% or 50% principal forgiveness instead of 100%, I am required pay the remaining 15% or 50% project costs at least 14 days **before** work can begin. I understand I must allow the local Health Department, EPA representatives and contractors to enter upon the property to make inspections.

I understand that the personal financial information contained in this application is necessary for the evaluation of my application for HSTS assistance. I understand that completing this application does not guarantee that my household will receive assistance. I understand that any authorized provider may rescind my contract if information is acquired which determines that my household is not eligible for services according to the rules of this program.

I hereby waive any and all present and future claims against the Carroll County Health Department, Carroll County Commissioners, its employees and Board Members for damages in any way connected with the repair for which I am making an application as a condition of receiving repair/replacement assistance. I understand that I have the opportunity to consult with an attorney before signing this waiver and application.

_____ _____

Applicant's Signature Date

_____ _____

Co-Applicant's Signature Date

RETURN COMPLETED APPLICATION AND SUPPORTING DOCUMENTATION TO:
Carroll County Commissioners
119 S. Lisbon Street, Suite 201
Carrollton, OH 44615