Summit County Dept. of Sanitary Sewer Services

1180 S. Main St. Suite 201 Akron, Oh. 44301 Ph. (330) 926.2400 Fax (330) 926.2470

Applicant Name: ____________________ **Spouse:** ____________

Homeowner Name: ____________________ **Phone No.** ____________

Service Address: ____________________ **D.O.S.S.S. Acct. #:** ____________

Applicant Birth Date: ____/____/____ **Spouse Birth Date:** ____/____/____ **# Residing in Home:** ________

Physician Verification of Disability Required if Applicable

Under Section 323.151 ORC provides "some impairment in body or mind that makes him unfit to work any substantially remunerative employment which he/she is reasonably able to perform and which will, with reasonable probability, continue for an indefinite period of at least 12 months without any present indication of recovery therefrom has been certified permanently and totally disabled by a state or federal agency having the function of so classifying persons."

Physician Name: ____________________ **PhysicianSignature:** ____________________

Address: ____________________ **Phone:** ____________________

Agency: ____________________ **Signature:** ____________________

Adjusted gross income requirements: $ SEE INCOME CHART. Including but not limited to adjusted gross income on bottom line of tax return form. You must also include as income any NONTAXABLE income. *(Proof of income requirement: current tax year 1099, W-2, 1040 or 1040-A, etc.) Must include entire household income*

ELIGIBLE INCOME	APPLICANT	SPOUSE
1. Adjusted Gross Income(from required form)	+ $	+ $
2. Social Security/Survivors	+ $	+ $
3.Total Income	+ $	+ $

____________________ ____________________

Applicant signature *date*

OFFICE USE ONLY

DATE RECEIVED: ____________________ ☐ ***APPROVED*** ☐ ***DENIED***

RECEIVED BY: ____________________ ***APPROVED BY:*** ____________________