CLEVELAND HEIGHTS
HOMESTEAD APPLICATION

APPLICANT NAME: _____ EMAIL: _____

FULL ADDRESS: _____

PHONE NUMBER: _____

_____

UTILITY ACCOUNT NO.: _____ DATE OF BIRTH: _____

REQUIRED

APPLICANT MUST OWN AND RESIDE AT PROPERTY: **Please Enclose a copy of a valid ID AND a copy of a Current Approval Letter or Bill from Cleveland Water or Northeast Ohio Regional Sewer District Providing Proof of Currently Receiving Discount.**

Adjusted Gross Income, Old Age & Survivors Benefits, Social Security, other Retirement Pension or Annuity, all interest and dividends from whatever source must be included in total income.

INCOME OF $41,000 OR LESS

APPLICANT'S ANNUAL (20_____) INCOME:$_____

SPOUSE'S ANNUAL (20_____) INCOME:$_____

TOTAL ANNUAL (20_____) INCOME:$_____

I AUTHORIZE THE CITY OF CLEVELAND HEIGHTS TO EXAMINE ANY FINANCIAL RECORDS THAT RELATE TO MY INCOME. I DECLARE UNDER PENALTIES OF PERJURY THAT THIS RETURN OF CLAIM (INCLUDING ANY ACCOMPANYING STATEMENTS) HAS BEEN EXAMINED BY ME AND TO THE BEST OF MY KNOWLEDGE AND BELIEF IS A TRUE, CORRECT AND A COMPLETE REPORT. IF ANY STATEMENT IS FALSIFIED, APPLICANT WILL LOSE THE PRIVILEGE OF THE HOMESTEAD SEWER RATE FOR THREE YEARS. IN THE EVENT THE PROPERTY IS SOLD, APPLICANT OR HIS AGENT AGREES TO NOTIFY THE CITY OF CLEVELAND HEIGHTS WHEN THE TITLE TRANSFERS.

DATE _____ **SIGNATURE** _____

PHYSICIAN'S STATEMENT - CERTIFICATE OF TOTAL DISABILITY PERMANENTLY AND TOTALLY DISABLED MEANS A PERSON WHO HAS, ON THE DATE OF APPLICATION, SOME IMPAIRMENT IN BODY OR MIND THAT MAKES ONE UNFIT TO WORK AT ANY SUBSTANTIALLY REMUNERATIVE EMPLOYMENT WHICH THE PERSON IS REASONABLE ABLE TO PERFORM AND WHICH WILL, WITH REASONABLE PROBABILITY, CONTINUE FOR AN INDEFINITE PERIOD OF AT LEAST TWELVE MONTHS WITHOUT ANY PRESENT INDICATION OF RECOVERY THEREFROM OR HAS BEEN CERTIFIED AS PERMANENTLY AND TOTALLY DISABLED BY A STATE OR FEDERAL AGENCY HAVING THE FUNCTION OF SO CLASSIFYING PERSONS." (R.C. 323.151)

I HEREBY CERTIFY THAT _____

WAS, AS OF _____, AND IS NOW TOTALLY AND PERMANENTLY DISABLED BY VIRTUE OF PHYSICAL DISABILITY _____ OR MENTAL DISABILITY _____.

DATE: _____ _____
PHYSICIAN/PSYCHOLOGIST SIGNATURE

LICENSE NO.: _____ _____
PRINTED NAME OF PERSON SIGNING

PHONE NO.: _____ _____
STREET ADDRESS, CITY, ZIP CODE

APPROVAL CONTINGENT UPON DOCTOR'S COMPLETION OF THIS PORTION.

PLEASE RETAIN YELLOW COPY FOR YOUR RECORDS AND RETURN THE COMPLETED WHITE COPY WITH DOCUMENTATION TO:
CITY OF CLEVELAND HEIGHTS, UTILITIES ADMINISTRATION, 40 SEVERANCE CIRCLE, CLEVELAND HEIGHTS, OH 44118
For Additional Information call: (216) 291-5995 (Utility Billing Option)