



CLEVELAND HEIGHTS HOMESTEAD SEWER RATE APPLICATION

APPLICANT NAME: _____
ADDRESS: _____
CITY AND ZIP CODE: _____
WATER ACCOUNT NO.: _____
DATE OF BIRTH: _____

PERMANENT PARCEL NUMBER: _____
(FROM YOUR REAL ESTATE TAX BILL)
PHONE NUMBER: _____
SOCIAL SECURITY NO.: _____

PROPERTY MUST BE OWNER OCCUPIED: Note: Enclose a copy of the deed or property tax bill AND Northeast Ohio Regional Sewer District (NEORS) Approval Form along with valid ID.

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 \$33,500 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