Public Health
Prevent. Promote. Protect.
Warren County Health District

Direct Financial Assistance Application for the Repair/Replacement/Sewer Connection of Failing Household Sewage Treatment Systems [HSTS]

APPLICANT'S INFORMATION

Name: _____ Date: _____

_____
Residential Address [note: Applicant must live in the home with failing HSTS]

_____ _____
Telephone Number E-mail Address

_____
Proof of Ownership: Attach Deed

Household Occupants [Notice, Health District may contact occupants]:

Name:	**Valid Phone Number:**

Proof of Income Eligibility: Attach the previous year's income tax returns for each household occupant:

Attach paycheck stubs for previous 3 months of each household occupant:

Describe Nature of Failing HSTS, include whether or not the HSTS has been inspected and determined to be a public health nuisance by Warren County Combined Health District:

NOTICE Regarding Income Eligibility
Based on the number of household occupants and combined household income, Applicants may receive 100%, 85%, or 50% of the eligible repair/replacement costs forgiven, or may not qualify for any cost forgiveness. The Applicant will be informed of their eligibility and the percentage of the award prior to approving this program application.

Applicant's Permission for Inspection and Entry on Land and Acknowledgement of Duties:

I, the undersigned, as the owner and occupant, hereby grant permission for the Warren County Combined Health District, its employees and agents, any necessary contractors, sub-contractors, site and soil evaluators, designer, or HSTS installer to enter upon my land, residence, and premises as determined necessary by the Warren County Combined Health District for the purposes of investigating or approving, this application, or any future related and approved HSTS permitting, soil evaluation, design, installation repair and/or replacement, in conjunction with this application.

Further, I the undersigned, hereby acknowledge that as a condition of the award of this grant I may be responsible to obtain all permits, permit coverage, and documentation of payment. I hereby acknowledge and agree by signing below that I will be responsible to make payment directly to the chosen contractor of my share of the costs of the HSTS repair or replacement,, and will be responsible for any and all future maintenance, or to obtain maintenance or service contracts for the installed HSTS as required by the Warren County Combined Health District in addition to being placed on the operation and maintenance program of the Warren County Combined Health District, if applicable.

Applicant's Signature: _____ **Date:** _____

_____ **Date:** _____

For Health District Use Only:

Is the Applicant's HSTS an eligible expense per Table H-1 and H-2 of the WPCLF Program Management Plan? Describe:

Has the Health District inspected and confirmed the HSTS is failing? Describe:

Proposed HSTS repair, partial replacement, or total system replacement:

Is the Applicant income eligible as described in the WPCLF Program Management Plan? Describe: