

**City of Brookville**  
**Application for Senior Citizen/Permanently & Totally Disabled Utility Discount**

**PLEASE READ REVERSE SIDE OF FORM AND INFORMATION SHEET BEFORE COMPLETING**

\_\_\_\_\_ Initial Application      \_\_\_\_\_ Renewal Application      Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_

Applicant Address \_\_\_\_\_

Are there other members of your household? Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, please list)

Name	Age	Birth Date	Relationship to Applicant
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Income Information:** All information for **2015** must be reported below on the appropriate lines. **Total household income** cannot be over **\$28,000**. Total income includes the income of the applicant, the income of the spouse of the applicant, and/or the income of all other residents of the household. Total income includes wages, salaries, business income, rents and other types of income. Total income also includes Social Security Retirement, Non-Taxable and Taxable Retirement Pension & Annuity, all Interest including Interest on Tax Exempt Government Obligations, and all other income.

	<u><b>Applicant</b></u>	<u><b>Spouse</b></u>	<u><b>All Others</b></u>
W-2 Wages	\$ _____	\$ _____	\$ _____
Social Security Retirement	\$ _____	\$ _____	\$ _____
Retirement Pension & Annuity	\$ _____	\$ _____	\$ _____
All Interest (Taxable & Non Taxable)	\$ _____	\$ _____	\$ _____
All Other Income for Given Year	\$ _____	\$ _____	\$ _____
<b>TOTAL HOUSEHOLD INCOME</b>	<b>\$ _____</b>		

(over)

**APPLICANT AFFIDAVIT**

State of Ohio, County of \_\_\_\_\_

The undersigned states that the statements contained in this Form are complete and true to the best of his/her knowledge and belief.

\_\_\_\_\_  
Signature of Applicant

**PLEASE READ THIS BEFORE YOU COMPLETE THE APPLICATION FORM**

**WHAT YOUR SIGNATURE MEANS:** By signing this form, you authorize the Finance Director to examine any financial records that relate to your income. You also affirm, under penalty of perjury, that all information on this application is accurate and true.

**QUALIFICATIONS:** To receive the utility discount, you must (1) be at least 65 years old during the year in which you file, or be permanently and totally disabled (see definition below); (2) have total income of not more than program limit; (3) own or rent, occupy your residence as your primary place of residence as of the year you file and receive a utility bill from the City of Brookville.

**CURRENT APPLICATION:** If you qualify for the utility discount for the first time this year, check the box titled Initial Application. However, if you qualified last year, and you wish to continue the discount, check the box titled Renewal Application.

\_\_\_\_\_  
**FOR FINANCE DEPARTMENT USE ONLY**  
\_\_\_\_\_

1099's \_\_\_\_\_

Form SSA-1099 \_\_\_\_\_

IRS Form 1040 \_\_\_\_\_

Granted \_\_\_\_\_

Denied \_\_\_\_\_

Account # \_\_\_\_\_

\_\_\_\_\_  
Sonja M. Keaton, Director of Finance

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**CERTIFICATE OF DISABILITY**

Section 232.151 O.R.C. provides that “Permanently and Totally Disabled” means a person who has some impairment in body or mind that makes him unfit to work at any substantially remunerative employment which he is reasonably able to perform and which will, with reasonable probability, continue for an indefinite period of at least twelve months without any present indication or recovery therefrom or has been certified as permanently and totally disabled by a state or federal agency having the function of so classifying persons.

In accordance with the above, I (we) hereby certify that \_\_\_\_\_ was, as of January 1, 20\_\_\_\_, and is now totally and permanently disabled by virtue of \_\_\_\_\_ physical disability or \_\_\_\_\_ mental disability.

\_\_\_\_\_  
**License Number**

\_\_\_\_\_  
**Physician (Signature)**

\_\_\_\_\_  
**Physician Name of Person Signing**

\_\_\_\_\_  
**Psychologist (Signature)**

\_\_\_\_\_  
**Address (please print)**

\_\_\_\_\_  
**Agency**

\_\_\_\_\_  
**City/State, Zip Code (please print)**

\_\_\_\_\_  
**If Agency: Signature and Title of Person  
Completing Form**

\_\_\_\_\_  
**Date**

**NOTE: All copies must be signed by physician.**