



# TOWN OF YARMOUTH

## BOARD OF HEALTH

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1146 ROUTE 28, SOUTH YARMOUTH MASSACHUSETTS 02664-4451  
Telephone (508) 398-2231 ext.241, Fax (508) 398-0836

### **Application for Reimbursement** **Health and Environmental Services in the Town of Yarmouth**

Applicants must be a Yarmouth property owner, residing in the home for which they are applying for assistance. This home must be the applicant's primary residence. Applicants applying for the first time must bring a copy of their driver's license, and their bank books or statements showing their balances as of July 1.

The applicant's eligibility is determined by their income and assets. **Married applicants, co-owners, and all members of the household over the age of 18 have to claim all income and assets.** Applicants must be domiciled at their property as of January 1.

**INCOME:** Income includes Social Security and any other pensions, any wages, salaries, and tips earned, interest and dividends from any monies in the bank or stocks, All of the above mentioned would be from the previous calendar year for which the applicants are applying. **The applicant and all household members must submit the previous calendar year's federal and state tax returns to assist in determining income.**

**ASSETS:** Assets include the applicant's and household members bank balances as of January 1, also any stocks, bonds, securities, IRA's, any other properties that have the applicants listed as a record owner or any other tangible assets.

The qualifying low and moderate income levels are attached to the back of the application.

### **PROCEDURES:**

Applications must be completed, signed, and returned to the Board of Health along with **copies of the applicant's previous year's state and federal tax returns.** For projects of \$1,000 or more the enclosed Quotation Report Sheet attached must be completed and submitted with the application.

**For all reimbursements, proof of payment will be required including a paid receipt from the contractor and a copy of the cancelled check.**

**Applicants applying for septic pumping reimbursement must make sure all septage is disposed of at the Yarmouth-Dennis Septage Treatment Plant.**

If you have any questions concerning this application: process, please feel free to contact the Yarmouth Health Department, Monday through Friday, 8:30 a.m. to 4:30 p.m., at (508)398-2231, ext. 241.

**HEALTH AND ENVIRONMENTAL SERVICES  
FINANCIAL GRANT REQUEST**

Applicant must complete entire application along with providing telephone numbers of all references.

Date \_\_\_\_\_

Name \_\_\_\_\_

Residential address \_\_\_\_\_  
\_\_\_\_\_

Telephone \_\_\_\_\_

List All Other Properties Owned: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Number of Members in Household: ( \_\_\_\_\_ )

<b>Members Of Household:</b>	<b>Name:</b>	<b>Age:</b>	<b>Social Security #:</b>
<b>Head Of House</b>			
<b>Spouse</b>			
<b>Other/Name</b>			
<b>Other/Name</b>			

<b>Please enter gross monthly income for each person in the household. Enter information in the appropriate box.</b>				
	<b>Head of House</b>	<b>Spouse</b>	<b>Other/Name</b>	<b>Other/Name</b>
<b>Employment</b>				
<b>TAFDC</b>				
<b>General Relief</b>				
<b>SSI</b>				
<b>Social Security</b>				
<b>VA Benefits</b>				
<b>Pension</b>				
<b>Unemployment</b>				
<b>Child Support</b>				
<b>Other(I.E. Rent</b>				
<b>Total</b>				
<b>Verification of Income (Contact number, name, agency, and address)</b>				

List of All Assets:

Cash \$

List Names Of Banks, Type Of Account, Amount In Account And Account Numbers For All Checking, Savings, Certificates Of Deposit, Etc:

<b>Household Members</b>	<b>Banks</b>	<b>Type Of Account</b>	<b>Amount In Account</b>	<b>Account Numbers</b>	<b>Checking/ Savings</b>	<b>Certificate Of Deposit</b>
<b>Head Of Household</b>						
<b>Spouse</b>						
<b>Other</b>						
<b>Other</b>						
<b>Other</b>						

Extraordinary Expenses (Specify Nature And Amounts):

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Fixed Expenses (Specify Payee And Amount Per Month):

<u>Item</u>	<u>Payee</u>	<u>Amount</u>
Mortgage	_____	_____
Mortgage Holder's Name & Address, Contact Person, Loan Account Number And Telephone Number:		
_____	_____	_____
_____	_____	_____

Utilities (Itemize Electric, Gas, Phone, Cable TV, Etc.)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other Funds Applied For (please check below):

Emergency Assistance                       Medicaid  
 Needy Fund                                       Bank Loans  
 Grants     Other (Specify): \_\_\_\_\_

Status of Request for Additional Funds:

(To Maximize The Grant Funds For Residents Of The Town Of Yarmouth, Applicants Must Make Efforts To Exhaust All Available Resources. Use This Section To Describe Your Efforts To Obtain Other Funds.):

Have You Applied For A Grant Request Previously (Please Circle):

Yes      or      No

Employment Information:

Employer Information	Head Of House	Spouse	Other	Other
Present Employer				
Type Of Work				
Unemployed				
Date Of Filing Unemployment				
Last Employers				
Type Of Work				

U.S. Department Of Housing And Urban Development's Community Development Block Grant Program Requires The Town Of Yarmouth To Collect Data, **Please Check One Or More Of The Boxes To Identify Race For All Persons In Your Household:**

<b>White</b>	
<b>Black/African American</b>	
<b>Asian</b>	
<b>American Indian/Alaskan Native</b>	
<b>Native Hawaiian/Other Pacific Islander</b>	
<b>American Indian/Alaskan Native &amp; White</b>	
<b>Asian &amp; White</b>	
<b>Black/African American &amp; White</b>	
<b>Am. Indian/Alaskan Native &amp; Black/African Am.</b>	
<b>Other Multi-Racial</b>	
<b>Asian/Pacific Islander</b>	
<b>Hispanic</b>	

**Please Circle If The Head Of Household Is Male Or Female:**

Male or Female

Name of Septic Pumping Company:

\_\_\_\_\_

Date of Last Septic System Pumping On Property:

\_\_\_\_\_

\*\*\*\*\*  
**PLEASE ALLOW 10 WORKING DAYS FOR VERIFICATION AND PROCESSING OF GRANT REQUESTS.**  
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Signature of Applicant:

\_\_\_\_\_

Print Name:

\_\_\_\_\_

Date:

\_\_\_\_\_

\*\*\*\*\*  
**I HEREBY CERTIFY ALL INFORMATION AND STATEMENTS PROVIDED ARE TRUE UNDER PENALTY OF PERJURY OF LAW.**  
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Health Department Use Only

Approved \_\_\_\_\_

Disapproved \_\_\_\_\_

Payment Amount: \_\_\_\_\_ Date of Payment \_\_\_\_\_

To Whom Payment Was Made: \_\_\_\_\_

Processed By: \_\_\_\_\_

Notes:

**Septic System Grant Request Liability Statement**

I, \_\_\_\_\_, Have Applied To The Town Of Yarmouth Septic System Inspection And Maintenance Grant For Assistance, And I Request Financial Status With Your Agency/Organization/Financial Institute In Order To Determine My Eligibility For The Fund Benefits. I, Hereby Release You From Any And All Liability, Including But Not Limited To Damages, Aiming Out Of The Release By You Of Any Such Information Requested. I Hereby, Further Authorize That A Photocopy Of This Authorization May Be Relied On As If It Were An Original.

\_\_\_\_\_  
Type Or Print Name Of Witness

\_\_\_\_\_  
Type Or Print Name Applicant

\_\_\_\_\_  
Signature Of Witness  
(To Be Signed In Ink)

\_\_\_\_\_  
Signature Of Applicant  
(To Be Signed In Ink)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date