



Erie County Health Department

2021 HSTS Replacement Program

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

City *State* *ZIP Code*

Phone: _____ Email: _____

Name of Property Owner on Record with the County: _____

Is the property currently listed for sale? YES NO If yes, are you the Buyer or Seller? Buyer Seller

If the applicant's name and the owner's name do not match, is there a Legally filed Land Contract? YES NO

Do you reside in the home? YES NO

Income

Income is determined by the total number of people living in the household. Please list below all persons living in the house including yourself. Age and income information are also required for each person.

| Name of household member | Relationship to applicant | Date of Birth | Receiving Income Yes or No |
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Proof of income is Required for all household members 18 years of age and older by providing one of the following forms of income listed below. Each income earner is asked to sign the form of income provided showing their portion of income.

Tax Return for the most recent year (if self-employed, please include Profit and Loss)

- Pay Stubs representing 4 consecutive weeks of pay.
(i.e. – weekly pays = 4 stubs, biweekly pays = 2 stubs, etc.)
- Statement or Letter indicating Social Security, Disability, Pension or Unemployment benefits
- Bank Statement showing interest earned or income deposits for one month (only if above are not available)

Septic System Information

Why do you believe your Septic System is Failing?

What is the approximate age of your existing septic system? _____

Do you have ponding sewage on your property? Yes _____ No _____

How often does the ponding occur? _____

Is there an eminent safety issue? i.e. – tank lid collapse _____

Have you received orders from the local Health Dept. to repair, replace or connect to sewer? _____

Permission to Enter the Property

Please read carefully and respond to this item.

I grant permission to all parties involved in the repair or replacement of my home sewage treatment system or sewer connection to my property, including but not limited to the county health department, representative(s) from the funding agency (Ohio EPA), soil evaluator, system designer, installers bidding on the work and the installer and their employees contracted by the county health department to repair/replace/connect my system.

I agree to allow entry as stated above. I Agree

Acceptance

Please read and respond to all these items carefully. Some statements indicate your willingness to pay for additional items not covered by the grant.

I understand that filling out this application does not entitle my household to funding from the 2021 Erie County HSTS Replacement Program until Great Lakes Community Action Partnership has notified grant awardees in writing on behalf of Erie County Health Department.

I Agree

Upon selection, I understand and agree to pay Erie County Health Department all monies required as administrative fees or matching grant funds, as notified to pay, based on my income eligibility percentage noted in the Letter of Approval.

I Agree and Understand

I further understand that bidding for any work will not commence until full payment of administrative fees being paid and tap-in, repair or replacement work will not commence until all required matching funds have been paid in full to Erie County Health Department.

I Agree and Understand

I understand that to be eligible to receive grant funding, I am required to obtain an operation permit as required by the local health department, which is not covered by these grant funds. Additionally, I am required to obtain and maintain any maintenance or service contracts as required by the local health department for the life of my system.

I Agree and Understand

Disclaimer and Signature

I certify the information I have provided in this application and for income verification, to the best of my knowledge, provide true, accurate and complete disclosure of the requested information.

Signature: _____ Date: _____

Please send, fax or email complete applications along with income verification to:

Nadine Thompson
GLCAP, Inc.
P O Box 590
Fremont, OH 43420

FAX: 419-333-6197

Email – nethompson@glcap.org.

PLEASE NOTE: NO PHOTOS OF APPLICATION OR INCOME WILL BE ACCEPTED.

Questions contact: Nadine Thompson at 419-334-3519 or Cindy Brookes at 419-397-2648.