Lake County
General Health District
5966 Heisley Road
Mentor, Ohio 44060

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Madison: **(440) 428-4348 .x 2543**
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Ron H. Graham, MPH, Health Commissioner
www.lcghd.org

FINANCIAL ASSISTANCE FOR REPAIR/REPLACEMENT OF FAILING HOME SEWAGE SYSTEM
WPCLF HSTS APPLICATION 2025

Applicant (Head of Household)

Full Name ____ **M____ F____**

Home Address _____________________________________**City**____________________**Zip**_____________

Home phone _________________ **Cell phone** _________________ **Email address** ______________________

Marital Status: Married____ Separated____ Unmarried (Inc. Divorced) ____

Employer ___________________________________ **Phone** ________________ **# of years employed** ______

Address ____**City**____________________**Zip**_____________

Co-Applicant

Full Name ____ **M____ F____**

Home Address _____________________________________**City**____________________**Zip**_____________

Home phone _________________ **Cell phone** _________________ **Email address** ______________________

Marital Status: Married____ Separated____ Unmarried (Inc. Divorced) ____

Employer ___________________________________ **Phone** ________________ **# of years employed** ______

Address ____**City**____________________**Zip**_____________

LIST ALL PEOPLE LIVING IN YOUR HOUSEHOLD INCLUDING YOURSELF:

Name	Relationship	Age	Employed? (Y/N)

TOTAL INCOME PER YEAR: All sources of income from each household member over 18 years of age must be included in table below.

***Please note: Documentation verifying income must be provided with this application. W2s, Previous year Tax returns, pay stubs, SSI documents, or other proof of total household income.**

Type of Income	Head of Household	Occupant 2	Occupant 3	Occupant 4
Base Employment (gross salary)				
Pension/Retirement				
Dividends, Interest				
Social Security				
Rental Income				
Welfare				
Alimony				
Unemployment				
Disability Compensation				
Other				

Total Household Projected Gross Income for current year: $____________________

Are you the owner and occupant of the property you are seeking assistance for? YES____ NO____

Have you had the property foreclosed upon? YES____ NO____

Do you own any other property? Rentals? YES____ NO____

APPLICANT RELEASE TO OBTAIN VERIFICATION OF INCOME

As an applicant to the WPLCF HSTS REPAIR/REPLACEMENT PROJECT, I (we) do hereby give my (our) permission to Lake County General Health District staff administering this Program to contact my (our) employer(s), or other person(s) or companies to verify information I (we) have supplied the County concerning my (our) income, home ownership, and occupants as reported herein by me (us).

______________________________________ ________________

Signature **Date**

______________________________________ ________________

Signature **Date**

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