ANNE ARUNDEL COUNTY DEPARTMENT OF HEALTH
Bureau of Environmental Health
3 Harry S. Truman Parkway
Annapolis, MD 21401

APPLICATION FOR ASSISTANCE
SEPTIC SYSTEMS, PRIVATE WELLS AND RADIUM WATER TREATMENT SYSTEMS

This application is designed to help evaluate your eligibility for assistance. This information will be confidential and incorporated into your case file. Please return this form to the address above. Thank you for your interest in the Well and Septic System Assistance Program.

Name:	**Date:**
Address:	**City:**
Home Phone:	**Work Phone:**

SEPTIC SYSTEM/PRIVATE WELL INFORMATION

Item(s) needing repair, replacement or installation:

_____Septic System **_____ Radium Water Treatment System**

_____Private Well

Describe the problems you are experiencing. _____

_____

_____

Is the deed to your home in your name? YES___ NO___
Are there any other names on the deed? YES___ NO___ If yes, list names:_____

ASSETS

DESCRIPTION	VALUE ($)
Checking & Savings Accounts - Name of Institution:	
Stocks & Bonds- Number & Description:	
Life Insurance Net Cash Value Face Amount (#_____)	
Subtotal Liquid Assets	
Real Estate Owned	
Vested Interest in Retirement Fund	
Net Worth of Business Owner - Attach Financial Statement	
Automobiles - Make & Year:	
Other Assets - Describe:	
Total Assets	

SCHEDULE OF REAL ESTATE OWNED

Address of Property	**Property Type** *(residential, commercial, rental, etc.)*	**Market Value**	**Mortgage Amount**	**Gross Rental Income**	**Mortgage Payments**	**Taxes, Insurance, Etc.**	**Net Rental Income**

HOUSEHOLD

People Living in the House	**Age**	**Gross Monthly Income**
1.		
2.		
3.		
4.		

(If necessary, use attachment for listing additional members.)

Please provide the last 3 years of Federal Tax Returns for everyone over 18 years of age in the household.

AUTHORIZATION OF CREDIT INVESTIGATION

I/We understand that the completion of this application authorizes the Controller of Anne Arundel County to verify my/our gross income(s) as reported on my/our last 3 Maryland State Income Tax Returns and the release of that information to the Anne Arundel County Department of Health.

I/We authorize Anne Arundel County Department of Health to obtain credit information for the purpose of evaluating this application and to disclose this information to the Comptroller of Maryland and local agencies participating in the programs.

_____ _____

Signature Date

_____ _____

Signature Date

CERTIFICATION OF INFORMATION

I certify that the above information is true, complete and accurate to the best of my knowledge. I realize that false, incomplete or inaccurate information will delay the processing of my application and could cause the application to be canceled. I hereby certify that I do not own or co-own any other property with or without improvements.

_____ _____

_____ _____