



OAKES WATER FUND ASSISTANCE PROGRAM APPLICATION

FOR YEAR OF: _____

File Application with City Auditor prior to February 1 of the year for which credit is requested.

APPLICANT INFORMATION

NAME: _____ DATE: _____

ADDRESS: _____

WHICH OF THE FOLLOWING WOULD BEST DESCRIBE THE TYPE OF OWNERSHIP OF YOUR RESIDENCE
(CHECK ONLY ONE):

- A. IS RECORDED IN YOUR (AND SPOUSE'S) NAME AS OWNER
- B. IS BEING PURCHASED BY YOU UNDER A CONTRACT FOR DEED
- C. IS HELD IN JOINT TENANCY WITH ONE OTHER THAN SPOUSE
- D. IS HELD UNDER A LIFE ESTATE IN PROPERTY
- E. IS HELD IN A REVOCABLE TRUST

DO YOU HAVE ASSETS IN EXCESS OF \$50,000 INCLUDING THE VALUE OF ANY ASSETS GIFTED OR OTHERWISE DIVESTED WITHIN THE LAST THREE YEARS, AND EXCLUDING THE UNENCUMBERED VALUE OF YOUR HOMESTEAD?

YES
NO

THE FOLLOWING IS AN ACCURATE ACCOUNT OF TOTAL INCOME FOR THE PRECEDING CALENDAR YEAR
(FOR NEGATIVE VALUES PLEASE ENTER "0")

APPLICANT'S AND SPOUSE'S INCOME FROM SOCIAL SECURITY BENEFITS (EXCLUDE MEDICARE) _____

APPLICANT'S AND SPOUSE'S INCOME FROM SALARY AND WAGE _____

APPLICANT'S AND SPOUSE'S INCOME FROM INTEREST _____

APPLICANT'S AND SPOUSE'S INCOME FROM ALL OTHER RESOURCES _____

DEPENDENTS' TOTAL INCOME FROM ALL SOURCES _____

TOTAL INCOME FROM ALL SOURCES _____

MEDICAL EXPENSES ACTUALLY PAID DURING THE YEAR AND NOT PAID FOR BY INSURANCE _____

TOTAL AMOUNT OF HEALTH AND HOSPITAL INSURANCE PREMIUMS (EXCLUDE MEDICARE) _____

MEDICINE AND DRUGS _____

DOCTOR, DENTIST, AND HOSPITAL COSTS _____

HEARING AIDS, EYEGLASSES, DENTURES, ETC. _____

TRANSPORTATION COSTS FOR MEDICAL CARE (37.5 CENTS PER MILE) _____

NURSING HOME CARE COSTS AND/OR HOME NURSING CARE COSTS _____

TOTAL MEDICAL EXPENSES _____

INCOME FROM ALL SOURCES EXCLUDING MEDICAL EXPENSES _____

I declare that this application has been examined by me and to the best of my knowledge and belief is a true and correct application. I am willing to furnish proof of age, income, and assets if requested to do so by someone authorized to administer this credit. I reside on the property described in this application.

SIGNATURE OF APPLICANT _____ DATE _____

APPLICATION IS
 APPROVED
 DENIED REASON: _____

SIGNATURE OF ADMINISTRATOR _____ DATE _____