

Septic Tank Program Eligibility Release Form

<p>Organization requesting release of information (PJ name, address, telephone, & date):</p> <p>Spartanburg County Community Development Department 9039 Fairforest Road P. O. Box 5666 Spartanburg, SC 29304 Phone: (864) 595-5300</p>	<p>Information Covered: Inquiries may be made about items initiated by applicant / client.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 60%;"></td> <td style="width: 20%; text-align: center; vertical-align: bottom;">Verification Required</td> <td style="width: 20%; text-align: center; vertical-align: bottom;">Initials</td> </tr> </table>		Verification Required	Initials
	Verification Required	Initials		
<p>Purpose: Your signature on this HOME Program Eligibility Release Form, and the signatures of each member of your household who is 18 years of age or older, authorize the above-named organization to obtain information from a third party relative to your eligibility and continued participation in the:</p> <p>HOME TBRA Coupon Program HOME First-Time Homeowners Program HOME Rental Rehabilitation Program HOME Homeowner Rehabilitation Program</p> <p>Privacy Act Notice Statement: The Department of Housing & Urban Development (HUD) is requiring the collection of the information derived from this form to determine an applicant's eligibility in a HOME Program and the amount of assistance necessary using HOME funds. This information will be used to establish level of benefit on the HOME Program; to protect the Government's financial interest; and to verify the accuracy of information furnished. It may be released to appropriate Federal, State, and local agencies when relevant, to civil, criminal, or regulatory investigators, and to prosecutors. Failure to provide any information may result in delay or rejection of your eligibility approval. The Department is authorized to ask for this information by the National Affordable Housing Act of 1990.</p> <p>Instructions: Each adult member of the household must sign a HOME Program Eligibility Release Form prior to the receipt of benefit and on an annual basis to establish continued eligibility. Additional signatures must be obtained from new adult members whenever they join the household or whenever members of the household become 18 years of age.</p> <p>NOTE: THIS GENERAL CONSENT MAY NOT BE USED TO REQUEST A COPY OF A TAX RETURN. IF A COPY OF A TAX RETURN IS NEEDED, IRS FORM 4506, REQUEST FOR COPY OF TAX FORM MUST BE PREPARED AND SIGNED SEPARATELY.</p>	<p>Income(all sources)</p> <p>Assets(all sources)</p> <p>Child Care Expense</p> <p>Handicap Assistance</p> <p>Expense(if applicable)</p> <p>Medical Expense (if applicable)</p> <p>Federal Preferences</p> <p>Other Preferences</p> <p>Other(list)</p> <p>Dependent Deduction <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Handicap/Disabled <input type="checkbox"/> Family Member <input type="checkbox"/> Minor Children</p> <p>Authorization: I authorize the above-named HOME Participating Jurisdiction and HUD to obtain information about me and my household that is pertinent to eligibility for participation in the HOME Program.</p> <p>I acknowledge that:</p> <ol style="list-style-type: none"> (1) A photocopy of this form is as valid as the original. (2) I have the right to review the file and the information received using this form (with a person of person of my choosing to accompany me). (3) I have the right to copy information from this file and to request correction of information I believe inaccurate. (4) All adult household members will sign this form and cooperate with the owner in this process. 			

Head of Household-Signature, Printed Name, and Date: HEAD	Other Adult Member of the Household-Signature, Printed Name, and Date: Family Member #2
X _____ Other Adult Member of the Household-Signature, Printed Name, and Date: Family Member #3	X _____ Other Adult Member of the Household-Signature, Printed Name, and Date: Family Member #4
X _____	X _____

This section to be completed by the Community Development Department

Date Received: _____

Community: _____

SPARTANBURG COUNTY
PUBLIC WORKS DEPARTMENT
SEPTIC TANK REHABILITATION/REPLACEMENT
APPLICATION FOR ASSISTANCE

Please Print In Ink

(All information is confidential. Must complete front and back of application. An incomplete application will not be considered)

Head of Household: _____
(Name) (Age) (Social Security Number)

Physical Address: _____
(Address) (City) (State) (Zip)

Mailing Address: _____
(Address) (City) (State) (Zip)

Home Telephone: _____

Employer/Source of Income: _____

Employer/Source of Income Address: _____
(Address) (City) (State) (Zip)

Employer/Source of Income Telephone(s): _____

Spouse: _____
(Name) (Age) (Social Security Number)

Employer/Source of Income: _____

Employer/Source of Income Address: _____
(Address) (City) (State) (Zip)

Employer/Source of Income Telephone(s): _____

Additional Family Member(s):

(Name) (Age) (Social Security Number)

(Name) (Age) (Social Security Number)

Ethnicity: (select only one) Hispanic/Latino _____ Not-Hispanic/Latino _____

Ethnic Origin: Black/African American _____ White/Caucasian _____ Asian _____

American Indian/Alaskan Native _____ Native Hawaiian/Other Pacific Islander _____

Black/African American & White _____ Asian & White _____

American Indian/Alaskan Native & White _____

American Indian/Alaskan Native & Black/African American _____

Other Multi-racial _____

Number in household: Children under 7 years _____ Children 7 to 17 years _____
Adults 18 to 62 years _____ Elderly over 62 years _____

Number of household members with a disability: _____

Total number in household: _____

Are you a female head of household: Yes No

Do you own your own home? Yes No

Is your residence a: mobile home house other _____

CERTIFICATIONS: The undersigned certifies that all information in this application, and all information furnished in support of this application, is given for the purpose of obtaining assistance from Spartanburg County and is true and complete to the best of the applicant's knowledge and belief. The undersigned hereby authorizes the Spartanburg County CD to obtain verification from any source named herein. The undersigned agrees to abide by the county's requirements in connection with any assistance made by Spartanburg County pursuant to this application and specifically certifies that it is his/her intention to continue to occupy the unit as his/her principal residence if such assistance is provided.

Signature of Applicant: _____ **Date:** _____

Signature of Co-applicant: _____ **Date:** _____

Please Return Application To:

Spartanburg County
Community Development Department
P O Box 5666
Spartanburg, SC 29304
Telephone: (864) 595-5300

WARNING: PENALTY FOR FALSE OR FRAUDULENT STATEMENT

U.S. Title 18, Section 1001, provides: "Whoever, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willingly falsifies...or makes any false, fictitious, fraudulent statement or representations, or makes or uses any false writing or document, knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined not more than \$10,000 or imprisoned not more than five years, or both."

VERIFICATION OF SOCIAL SECURITY BENEFITS

<p>(Name of HOME Participating Jurisdiction)</p> <p>SPARTANBURG COUNTY COMMUNITY DEVELOPMENT DEPARTMENT 9039 FAIRFOREST ROAD P O Box 5666 SPARTANBURG, SC 29304 PHONE: (864)595-5300</p> <p>AUTHORIZATION: Federal Regulations require us to verify Social Security Benefit Income of all members of the household applying for participation in the HOME Program which we operate and to reexamine this income periodically. We ask your cooperation in supplying this information. This information will be used only to determine the eligibility status and level of benefit of the household.</p> <p>Your prompt return of the requested information will be appreciated.</p>	<p>Social Security Data</p> <p>_____ Date of birth</p> <p>_____ Gross monthly Social Security Benefit amount, type of benefit</p> <p>_____ Gross monthly Supplemental Security income payment amount (including State supplement), type of benefit</p>
<p>RELEASE: I hereby authorize the release of the requested information.</p> <p>_____</p> <p>(Signature of Applicant)</p> <p>Date: _____</p> <p>Or a copy of the executed "HOME Program Eligibility Release Form," which authorizes the release of the information requested, is attached.</p>	<p>Signature of _____ or Authorized Representative</p> <p>_____</p> <p>Title: _____</p> <p>Date: _____</p> <p>Telephone: _____</p>
<p>WARNING: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government.</p>	

Verification of Employment

<p>(Name of HOME Participating Jurisdiction)</p> <p>SPARTANBURG COUNTY COMMUNITY DEVELOPMENT DEPARTMENT 9039 FAIRFOREST ROAD P O Box 5666 SPARTANBURG, SC 29304 PHONE: (864)595-5300</p> <p>AUTHORIZATION: Federal Regulations require us to verify Employment Income of all members of the household applying for participation in the HOME Program which we operate and to reexamine this income periodically. We ask your cooperation in supplying this information. This information will be used only to determine the eligibility status and level of benefit of the household.</p> <p>Your prompt return of the requested information will be appreciated.</p>	<p>Employed since: _____ Occupation: _____</p> <p>Salary: _____</p> <p>Effective date of last increase: _____</p> <p>Base pay rate: \$_____/Hour; or \$_____/Week; or \$_____/Month</p> <p>Average hours/week at base pay rate: _____ Hours</p> <p>No. weeks _____, or No. weeks _____ worked/Year</p> <p>Overtime pay rate: \$_____/Hour</p> <p>Expected average number of hours overtime worked per week during next 12 months _____</p> <p>Any other compensation not included above (specify for commissions, bonuses, tips, etc.): For: _____ \$_____ per _____</p> <p>Is pay received for vacation? Yes No If Yes, no. of days per year _____</p> <p>Total base pay earnings for past 12 mos. \$_____</p> <p>Total overtime earnings for past 12 mos. \$_____</p> <p>Probability and expected date of any pay increase: _____</p> <p>Does the employee have access to a retirement account? Yes No If Yes, what amount can they get access to: \$_____</p>
<p>RELEASE: I hereby authorize the release of the requested information.</p> <p>_____</p> <p>(Signature of Applicant)</p> <p>Date: _____</p> <p>or a copy of the executed "HOME Program Eligibility Release Form," which authorizes the release of the information requested, is attached.</p>	<p>Signature of _____ or Authorized Representative</p> <p>_____</p> <p>Title: _____</p> <p>Date: _____</p> <p>Telephone: _____</p>
<p>WARNING: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government.</p>	