

**PICKAWAY COUNTY GENERAL HEALTH DISTRICT**

P.O. BOX 613 CIRCLEVILLE, OHIO 43113

Phone: (740) 477-9667 ♦ Fax: (740) 474-5523 ♦ Clinical Health Fax (740) 420-6102



Planning - Developing  
Educating - Implementing

**INTAKE FOR WPCLF ASSISTANCE TO REPAIR OR REPLACE A FAILING HOUSEHOLD SEWAGE TREATMENT SYSTEM**

**Applicant Information**

Owner Name:		Date:	
Address:	City:	State:	Zip:
Email:	Phone:	Cell Phone:	

Is the title to the property listed under the occupant's name?  Yes  No

Is the dwelling the owner's primary residence?  Yes  No

Is your home currently for sale, has it been for sale within the last 6 months, or do you plan on selling your home within the next 6 months?  Yes  No

State the name, age, and income of all individuals in the household:

- 1. \_\_\_\_\_ Age \_\_\_\_\_ Income \$ \_\_\_\_\_
- 2. \_\_\_\_\_ Age \_\_\_\_\_ Income \$ \_\_\_\_\_
- 3. \_\_\_\_\_ Age \_\_\_\_\_ Income \$ \_\_\_\_\_
- 4. \_\_\_\_\_ Age \_\_\_\_\_ Income \$ \_\_\_\_\_
- 5. \_\_\_\_\_ Age \_\_\_\_\_ Income \$ \_\_\_\_\_

Total Household income \$ \_\_\_\_\_

**\*Attach all income verification documents to this application (Last two months of pay stubs, Security Statements, or copies of all W-2 forms, Tax Returns, etc.)**

**I/We; the undersigned, certify that to the best of my knowledge and belief that all of the information on this form is correct.**

**Owner Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

***Eligible projects will be selected based on the severity of the failure, risk to environment and availability of funds. Completion of this application does not guarantee selection for the WPCLF program. Incomplete applications will not be considered for funding.***

Application received by:	Date:
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