



**2016/2017 APPLICATION
FOR UTILITY DISCOUNT
RATE EXEMPTIONS - ORDINANCE NO. 5361**

Telephone: 253-931-3038 Fax: 253-876-1900
 Mailing Address: 25 W Main St, Auburn WA 98001
 Email: Utilities@AuburnWA.gov

Name(s) on Account: _____ Utility Account No.: _____
 Applicant Name: _____ Phone Number: _____
 Address: _____ Zip: _____
 Driver's License or ID Card: _____

The undersigned certifies, subject to the penalties of perjury, that:

- The City Utility account is in his/her name, is living at the resident address listed above and is receiving water, sewer, storm, and/or garbage services.
- The undersigned is a least 62 years of age **OR** is *permanently disabled.
**Persons applying for the disability reduction for the first time must have their physician complete the form on the back of this application; subject to verification.*
- There are ___ residents living in the household (not including applicant).

Please list names, date of birth, and relationship to you in the box below.

Name	Date of Birth	Relationship to You

- Undersigned is **NOT** receiving additional utility allowances or rent subsidies from another governmental agency (HUD Section 8, King County Housing, etc.).
- The **combined total gross income** from the undersigned and all adults 18 years and older in the household from **January – December 2015** was \$_____.

Income Limits:

1 Person	2 Persons	3 Persons	4 Persons	5 Persons
\$31,650	\$36,150	\$40,650	\$45,150	\$48,800

Signature: _____ **Date:** _____

FOR OFFICE USE ONLY

Date Received:		Approved By:	Date:
Received By:		Denied By:	Date:
Counted:	Logged:	<input type="checkbox"/> Renewal <input type="checkbox"/> New	

**CITY OF AUBURN UTILITY DISCOUNT
2016/2017 APPLICATION FOR UTILITY RATE EXEMPTIONS
AFFIDAVIT FOR CLAIM OF DISABILITY - (FIRST TIME APPLICANTS ONLY)**

The undersigned certifies, subject to the penalties of perjury, that the applicant meets the following criteria for receiving the exemption for utility services:

*“The applicant is **permanently disabled** in that the individual has lost both legs and arms or one leg and one arm, or total loss of eyesight, or is paralyzed or suffering from some other condition **permanently incapacitating** the applicant from ever performing any work at any gainful occupation.”*

To be completed by Physician Office: (Please Print)

Applicant

Name: _____

Address: _____

Physician

Business Name: _____

Physician Name: _____

Business Address: _____

Business Telephone: _____

Physician Name (print): _____

Physician Signature: _____

Date: _____

Verification Required:

Physician Office Stamp OR Letter on office letterhead.