

TOWN OF DEEP RIVER SENIOR HOMEOWNERS PROGRAM - GRAND LIST YEAR: _____
FILING PERIOD: FEBRUARY 1 THROUGH MAY 15

Unique ID Number: _____			List Number: _____		
1. Applicant's Name: _____			DOB: - -	Social Security#: - -	
_____ Last	_____ First	_____ Middle			
2. Spouse Name: _____			DOB: - -	Social Security#: - -	
_____ Last	_____ First	_____ Middle			
3. Property Location _____			Other name on Property: _____		
4. Mailing Address: _____			Town: _____	State: _____	Zip: _____
FILING STATUS:					
5. Married: _____		Single: _____		Surviving Spouse (Age 50-65) Proof Required: _____	
PROOF REQUIRED:					
6. Is Spouse a resident of a Health Care/Nursing Home in CT., and on Title XIX: (Proof Required) Yes: _____ No: _____					
7. Is applicant totally disabled? Yes: _____ No: _____ Attach proof _____					

8. INCOME RECEIVED DURING LAST CALENDAR YEAR

- | | |
|---|----------|
| A. TAXABLE INCOME | A. _____ |
| B. NON-TAXABLE INCOME | B. _____ |
| C. SOCIAL SECURITY OR RAILROAD RETIREMENT | C. _____ |
| D. ANY INCOME NOT INCLUDED ABOVE | D. _____ |
| (Describe _____) | |
| E. TOTAL OF LINES 8A THROUGH 8D | E. _____ |

9. APPLICANT'S OR AUTHORIZED AGENTS'S AFFIDAVIT

The applicant or authorized agent deposes that the above statements are true and complete and claims tax relief under provisions of the Town of Deep River Adopted Ordinance. The property, for which tax relief is claimed, is the principal residence/domicile of the applicant. The applicant is not receiving Elderly or Homeowner Tax Benefits other than that what the applicant is receiving for the Town of Deep River or the State Connecticut. The penalty for making a false affidavit is the refund of all benefits received. The amount due will be treated as taxes not paid from the due date and will be subject to interest and penalties as prescribed by law. Your signature signifies that this affidavit has been read and understood.

SIGNATURE OF APPLICANT OR AUTHORIZED AGENT _____	DATE _____	PHONE _____	AGENTS RELATIONSHIP _____
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STOP! DO NOT WRITE BELOW THIS LINE - FOR ASSESSOR USE ONLY

Property Gross Assessment: _____	Are you on St. Elderly Program: Yes ___ No ___
Subtract Exemptions For:	Date of Acquisition: _____
Blind - _____	Percent Ownership of Property: _____ %
Disabled - _____	Town Benefit: _____ (Max)
Veterans - _____	% Ownership X _____
Additional Veterans - _____	
Local Options - _____	*TOTAL TOWN BENEFIT _____
Net Assessment: _____	
Mill Rate: _____	
Taxes: _____ - State Elderly Benefit _____ - Town Benefit _____ = _____ (Applicant's Tax)	

This is not a bill

ASSESSOR'S AFFIDAVIT

_____ I am satisfied that the above named applicant meets all the necessary requirements.
_____ This claim is disallowed for the following reason: _____
Please see the instructions at the Assessor's Office if you need to appeal this decision.

SIGNATURE OF ASSESSOR OR MEMBER OF ASSESSOR'S STAFF _____	Date Signed _____
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