CITY OF MEMPHIS
SOLID WASTE FEE AND SEWER RATE DISCOUNT APPLICATION

APPLICATION

1. **Applicant's Name:** (Please print) ____

2. **Street Address**: ______________________________________ **Zip Code**: ________
   * Discount shall only be applied to one address per applicant.

3. **Telephone**: ______________________________ **Date of Birth:**_____________

4. **Provide a copy of the most recent MLGW utility bill (must be in applicant's name).**

5. **Provide a copy of applicant's birth certificate, driver's license or state i.d.**

6. **How many people live at the applicant's address?** ______________

   ●List the names and 2014 calendar year income(s) of each person below:

	(Print Names) First / Middle / Last	Date of Birth (mo/day/yr)	Gross Income in 2014
Applicant			$
other			$
other			$
			$
(If more than four people, list separately)	Total Household Income		$

* Gross annual income(s) includes all wages, pensions, social security, interests, dividends, etc. (not net)

7. **Attach proof of annual (gross) income for yourself and each person listed above.**
   (ex: Federal Income Tax document(s) and/or Social Security Statement(s) from most recent year)
   If you filed Federal Income Tax, submit copy of Tax Return and SSI statement. (No Check Stubs or Bank Statements)

8. **Is applicant under 65 and totally (100%) disabled*?** **(circle one) YES NO**
   If YES, please have the disability verification on the back of this page completed and signed by your physician
   If you are 65 years of age or older, a disability verification is **not** necessary.
   *** (For Public Works purposes the term "Totally Disable" is defined as being unable to engage in any substantial gainful activity because of a physical or mental condition. A physician must determine if the condition has lasted, or is expected to last, at least one or more years or can lead to death.)**

9. I certify to the best of my knowledge that all the information provided by me is true and correct. I also authroize the verifcation of any and all information for the purpose of certification. I understand that anyone who fraudulently covers up a material fact or who knowingly gives false infroamtion required for eligibility determination is liable to prosecution under applicable criminal laws.

   APPLICANT SIGNATURE: ________________________________ **DATE:** _________

10. **Notarize here:** In the county of Shelby, sworn and subscribed before me on ___ day of __________ 20___.
    Notary signature: ________________________________

11. **Return application form to:**

    City of Memphis Solid Waste Fee Dept.
    125 N. Main, Room 640
    Memphis, TN 38103

(Notary Seal Here)

FOR OFFICE USE ONLY - Applicant does not complete below

Received:	Reviewed:	Entered:

DISABILITY VERIFICATION
Must be completed and signed by Physician

The following patient is **under 65 years of age** and, if verified as being totally disabled, may qualify to continue receiving City of Memphis Solid Waste Fee and Sewer Rate discounts. Therefore, the patient's physician must provide the following information and must sign in order to receive the discounts.

Patient Name: ______________________________ **Date of Birth:** ______________

Is the above person your ongoing patient? **(check one)** ❑ **Yes** ❑ **No**

Current Health Issue(s): ____

Which of the following best describes the patient's overall health? **(check one)**

- ❑ **Good physical and mental health.** (Patient has no significant illnesses or disabilities. Only routine medical care such as annual checkups is required.)
- ❑ **Mild physical and/or mental impairment.** (Patient has only minor illnesses and/or disabilities which might benefit from medical treatment or corrective measures.)
- ❑ **Moderate physical and/or mental impairment.** (Patient has one or more diseases or disabilities which are either painful or require substantial medical treatment.)
- ❑ **Total physical and/or mental impairment.** (Patient has one or more illnesses or disabilities which require extensive medical treatment which are either severely painful or life threatening.)

Is medical improvement…… **(check one)**

❑ **Expected** ❑ **Possible** ❑ **Not expected**

Is the patient currently physically able to work? **(check one)** ❑ **Yes** ❑ **No**

- **If no, do you anticipate patient being able to work again?** ❑ **Yes** ❑ **No**
- **If yes, will patient return to work in the next 12 months?** ❑ **Yes** ❑ **No**

The responses to the above questions are complete and accurate to the best of my knowledge:

Physician Signature: __________________________________ **Date:** ______________
(signature stamp is not acceptable)
Medical Specialty: __________________________________ **Phone:** _____________

Office Address: ____

Patient Signature: _____________________________________ **Date:** ______________

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