



Office of the Tax Assessor
The City of Waterbury
Connecticut

RENTERS REBATE INFORMATION

ELDERLY AND TOTALLY DISABLED

APPLICATIONS WILL BE TAKEN AT THE ASSESSOR'S OFFICE BEGINNING APRIL 1, 2024 THROUGH OCTOBER 1, 2024.

TO QUALIFY PERSONS MUST BE 65 YEARS OF AGE OR OLDER BY DECEMBER 31, 2023 OR BE 100% TOTALLY DISABLED BEFORE TURNING 65 RECEIVING BENEFITS FOR ENTIRE YEAR OF 2023.

APPLICANTS MUST SHOW PROOF OF RENT PAID (LETTER FROM OWNER OF PROPERTY STATING THE AMOUNT PAID FOR RENT FOR THE YEAR), GAS AND/OR ELECTRIC PAYMENT HISTORY OR OIL IN THE FORM OF PAID RECEIPTS, CANCELLED CHECKS FOR THE ENTIRE YEAR. NO POSTAL MONEY ORDERS OR ANY OTHER MONEY ORDER RECEIPTS OR VERBAL DOCUMENTATION WILL BE ACCEPTED AS PROOF OF RENT PAYMENTS.

INCOME PROOF CONSISTS OF ALL TAXABLE AND NON-TAXABLE INCOME FOR THE ENTIRE YEAR OF 2023, IN THE FORM OF FEDERAL INCOME TAX RETURNS, W2 FORMS AND 1099 STATEMENTS OF INCOME FOR ENTIRE YEAR.

A PERSON WHO HAS A SPOUSE IN A NURSING HOME CAN SUBMIT A LETTER FROM THE NURSING HOME ADMINISTRATOR STATING THE SPOUSE IS ON THE TITLE 19 PROGRAM. PERSONS RECEIVING STATE FINANCIAL ASSISTANCE CAN APPLY BUT THE ASSISTANCE PAYMENTS WILL AFFECT THE AMOUNT OF THE CHECK THEY WOULD HAVE RECEIVED.

PERSONS WISHING TO APPLY UNDER THE TOTALLY DISABLED PORTION ON THIS PROGRAM MUST FURNISH A TPQY STATEMENT FROM THE SOCIAL SECURITY OFFICE OR WRITTEN DOCUMENTATION FROM ANY OTHER GOVERNMENT SOURCE STATING APPLICANT IS TOTALLY DISABLED AND DATES OF CERTIFICATION OR SOCIAL SECURITY 1099 FORM SHOWING A MEDICARE DEDUCTION. VETERANS PENSIONS AND RAILROAD RETIREMENT EARNINGS ARE ALSO INCLUDED.

APPLICANTS ARE ASKED TO BE SURE THEY HAVE ALL THE NECESSARY PAPERWORK WITH THEM WHEN THEY FILE OR THE APPLICATION CANNOT BE PROCESSED AT THAT TIME.

INCOME GUIDELINES: SINGLE 43,800 MARRIED 53,400.

ASSESSOR'S OFFICE, 235 GRAND ST, WATERBURY CT 06702

APPLICATION FOR RENTER'S
REBATE OF ELDERLY RENTERS

AND TOTALLY DISABLED PERSONS

RENTER

FILING PERIOD APRIL 1 - OCT. 1

1. NAME (Last)	(First)	(Middle Initial)	YOUR BIRTH DATE (Mo, Day, Yr)	YOUR SOCIAL SECURITY NO.
			/ /	- -
2. SPOUSES NAME (Last)	(First)	(Middle Initial)	SPOUSES BIRTH DATE (Mo, Day, Yr)	SPOUSES SOCIAL SECURITY NO.
			/ /	- -
3. PRESENT MAILING ADDRESS (No. and Street)		CITY OR TOWN (Don't Abbreviate)		STATE ZIP CODE
4. RENTAL ADDRESS IN CT IF DIFFERENT THAN ABOVE		CITY OR TOWN		STATE ZIP CODE
5. FILING STATUS :				
CHECK ONLY ONE : <input type="checkbox"/> MARRIED <input type="checkbox"/> UNMARRIED <input type="checkbox"/> CIVIL UNION <input type="checkbox"/> SURVIVING SPOUSE (AGE 50 TO 65) PROOF REQUIRED				
IF SPOUSE IS A RESIDENT OF A HEALTH CARE OR A NURSING HOME FACILITY IN CT AND ON TITLE XIX <u>PROOF REQUIRED</u>		NURSING HOME	IF APPLICANT IS TOTALLY DISABLED <u>CURRENT</u> <u>PROOF REQUIRED</u>	TOTALLY DISABLED CHECK HERE: <input type="checkbox"/>
		CHECK HERE: <input type="checkbox"/>		
6. WHAT % OF RENT AND UTILITIES DO YOU PAY? (Husband and Wife are considered to be one (1) renter)				%
7. TOTAL RENT AND UTILITIES ACTUALLY PAID BY APPLICANT/APPLICANTS				\$
8. DID OR WILL YOU FILE A FEDERAL TAX RETURN FOR LAST YEAR? <input type="checkbox"/> - YES (Attach Copy) <input type="checkbox"/> - NO				
9. PUBLIC ASSISTANCE RECIPIENTS PLEASE NOTE: You may receive LESS than the TENTATIVE GRANT on Line 20 below.				
10. DID YOU RENT IN CONNECTICUT FOR THE ENTIRE CALENDAR YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. IF THE ANSWER TO (10) IS "NO", ENTER DATES YOU RENTED:		Starting Mo, Yr
				Ending Mo, Yr
12. INCOME RECEIVED DURING LAST CALENDAR YEAR:				
A. GROSS INCOME - Includes: Federal Gross income or its equivalent. Such as, but not limited to, wages, lottery winnings, taxable pensions, IRA's, interest, dividends and net rental income (exclude depreciation).			A.\$ _____	
B. NON-TAXABLE INTEREST - Example: Interest from Tax Exempt Government Bonds			B.\$ _____	
C. SOCIAL SECURITY OR RAILROAD RETIREMENT INCOME - Add Medicare premiums (Attach SSA 1099)			C.\$ _____	
D. ANY INCOME NOT REFLECTED IN THE ABOVE - Examples: Federal Supplemental Security Income, Veteran's Pensions, Veteran's Disability Payments, and any other income not listed above.			D.\$ _____	
SPECIFY SOURCE OF INCOME:			E. TOTAL Add lines 12A through 12D E.\$ _____	
APPLICANT'S/ AUTHORIZED AGENT'S AFFIDAVIT	The applicant or authorized agent deposes that the above statements are true and complete and claims tax relief under provisions of the Connecticut General Statutes. The property for which tax relief is claimed, is the permanent residence/domicile of the applicant. He/she is not receiving State Elderly tax benefits under section 12-129b, section 12-170aa, in any town. I grant permission to the Department of Social Services to release to the Office of Policy and Management information necessary to help determine my eligibility. The penalty for making a false affidavit is the refund of all credits improperly taken and a fine of \$500.00 or imprisonment for one year, or both. Your signature signifies that this affidavit has been read and understood.			
SIGNATURE OF APPLICANT OR AUTHORIZED AGENT	Date signed (Mo, Day, Yr)	APPLICANT'S OR AGENT'S PHONE NO.	AGENT'S RELATIONSHIP	
X	/ /	()		

STOP! DO NOT WRITE BELOW THIS LINE - FOR ASSESSOR'S USE ONLY

13. Amount of rent and utilities paid from Line 7 \$	X .35	\$
14. CREDIT COMPUTATION: QUALIFYING INCOME		
<input type="checkbox"/> FULL YEAR - \$	x.05 (OR) <input type="checkbox"/> PART YEAR - \$	X (NO. MONTHS / 12) x .05 = \$
15. Subtract Line 14 from Line 13. If zero or negative amount, there is no benefit. Enter -0- on Line 20.		\$
16. Indicate table used: <input type="checkbox"/> Unmarried <input type="checkbox"/> Married		
17. MAXIMUM CREDIT ALLOWED		
A. <input type="checkbox"/> FULL YEAR: amount per table (OR) B. <input type="checkbox"/> PART YEAR: amount per table X (No. of Months() / 12 =)		\$
18. Enter amount on Line 15 or Line 17, whichever is LESS		\$
19. Minimum per table		\$
20. Enter GREATER of Line 18 or 19: TENTATIVE GRANT (Subject to review by Off. of Policy and Management)		\$
ASSESSOR'S AFFIDAVIT	___ - I am satisfied that the above named applicant meets all the necessary statutory requirements ___ - This claim is disallowed for the following reason: _____ Please see the instructions at the Assessor's or Local Social Services Office for appeal information.	
SIGNATURE OF ASSESSOR OR MEMBER OF ASSESSOR'S STAFF	Date signed (Mo.,Day,Yr.)	
	/ /	