REDEVELOPMENT AUTHORITY OF THE COUNTY OF WESTMORELAND (RACW)
ACCESSIBILE HOUSING PROGRAM
Please Print or Type
***ALL INFORMATION IS KEPT CONFIDENTIAL; PURPOSE IS TO VERIFY APPLICANT'S IDENTITY**

1. Applicant Name:_____ Age:_____ S.S. #_____
Parent/Guardian Name if under 18:_____ Age:_____ S.S. #_____
Address:_____
_____e-mail:_____
Telephone No. Home:_____ Cell:_____
Applicant Employer:_____ Occupation:_____
Address:_____ Length of Employment:_____
Parent/Guardian Employer:_____ Occupation:_____
Address:_____ Length of Employment:_____

2. Have you applied or received assistance/services from any of the following agencies or programs: Area Agency on Aging; Behavioral Health and Developmental Services; Veteran's Affairs; Case Management; Consolidated Waiver, Long Term Services and Support? If so, which Agency/Service:
_____

3 Doctor Name:_____Telephone No.:_____
Address:_____

***MUST INCLUDE LETTER FROM DOCTOR DOCUMENTING PERMANENT PHYSICAL DISABILITY**

4. Check which modification you are seeking: Ramp [ ] OR Residential Stair Lift [ ]
Briefly describe your need for the modification and urgency of need:
_____
_____
Do you currently have other home disability modifications? No [ ] Yes[ ] If Yes Explain:_____
_____

5. Owner of Property: Yes [ ] No [ ] If No, Name of Landlord_____
Occupants of Property: Yes [ ] No [ ]
Tax Map Number (located on Property Tax Bill) :_____
Total number of property occupants:_____

List the name & age of all property occupants whether or not they are related to you:

Full Name	Age

6. Gross amount of income per month (prior to deductions of all property occupants over the age of 18. Include wages, net business income, unemployment/worker's compensation, public assistance, social security, pensions, black lung, alimony, rental income, interest, dividends, etc.)

	Amount	Source
Applicant:	$_____	_____
	$_____	_____

Other Property Occupants	Amount	Source
	$_____	_____
	$_____	_____
	$_____	_____

7. **Required Documentation to be submitted with this application to be considered for assistance:**

a) Copy of most recent filed Federal Tax Return with signatures / Social Security Statement
b) Documentation of permanent physical disability from a medical professional

I/WE CERTIFY THAT THE ABOVE INFORMATION IS BEING COLLECTED TO DETERMINE MY/OUR ELIGIBILITY FOR ASSISTANCE. FOR APPROVAL PURPOSES, I/WE AUTHORIZE THE RACW TO : VERIFY ALL INFORMATION PROVIDED ON THIS APPLICATION; CONTACT OTHER SOURCES TO VERIFY AND SHARE INFORMATION/SERVICES; CONTACT OTHER SERVICES IN ORDER TO PROVIDE THE APPLICANT THE MOST ASSISTANCE POSSIBLE RELEASE ANY INFORMATION TO THE APPROPRIATE FEDERAL, STATE, OR LOCAL AGENCY INVOLVED WITH THIS PROGRAM. I/WE CERTIFY THAT THE INFORMATION GIVEN ON THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT FALSE STATEMENTS OR INFORMATION IS CONSIDERED FRAUD AND CAUSE FOR TERMINATION FROM THE PROGRAM. ALSO, I/WE UNDERSTAND THAT FALSE INFORMATION COULD BE PUNISHABLE BY LAW.

_____	_____
Applicant Signature	Parent/Guardian Signature
_____	_____
Date	Date

Please allow at least 60 days for a completed application to be processed.

IF YOU HAVE ANY QUESTIONS, CONTACT THE AUTHORITY'S STAFF AT 724-830-3050.
Mail completed forms & supporting documents to:

Redevelopment Authority of the County of Westmoreland
Fifth Floor, Suite 520
40 North Pennsylvania Avenue
Greensburg, PA 15601
www.westmorelandredevelopment.com

FOR OFFICE USE ONLY

Income: Per Month $_____ Per Year $_____
Authorized Signature: _____ Date:_____