REQUEST FOR SAUSALITO RESIDENTIAL REHABILITATION/ HOME ADAPTATION PERMIT GRANT

APPLICANT INFORMATION *Please have the individual who is applying to qualify for the grant program complete the following:*

Applicant Name: _____ Date : ____/ ____/ ____

Applicant Address**: _____

Signature: _____

*** The applicant address must be a Sausalito residence. If the owner of the property **IS NOT** the applicant, a signed letter of written consent from the owner is required. Only Sausalito Homeowners are eligible for the low-income associated grants.*

ELIGIBILITY

I/We are applying as a (check one, only; please make sure to provide a signature certifying information is correct):

☐ **Resident/Homeowner of Sausalito age 60 and older; complete the following:**
Age: _____ Date of Birth: _____/_____/_____

_____ _____
Applicant Signature *Date*

☐ **Low-income Sausalito Homeowner; complete the following:**
Gross Annual Household Income: $_____ Size of Household: _____

_____ _____
Applicant Signature *Date*

☐ **Resident/Homeowner who need home adaptations due to disabilities.** *Program Eligibility for residents of Sausalito under age 60 is determined by possession of a California DMV Permanent Disabled Person Placard issued to the applying resident, or by certification of a medical provider. Please fill out OPTION 1 or OPTION 2 below as applicable.*

OPTION 1 *CA DMV DISABLED PLACARD*

CA DMV Placard Number #_____ Signature X: _____

OPTION 2 *AUTHORIZED MEDICAL PROVIDER'S SIGNATURE AND CERTIFICATION Please complete all the information below. Incomplete forms will be returned to applicant.*

Authorized Medical Provider Information *(Please print the following information)*

Medical Provider Name: _____ Tel.: ____- ____- _____
Medical Provider Address: _____
Medical License Number: _____
I certify that I am: *(Please check one)*

☐ Physician ☐ Surgeon ☐ Chiropractor

☐ Optometrist ☐ Physician Assistant ☐ Nurse Practitioner

I certify that the applicant _____ is permanently disabled and would benefit from Accessible Home Modifications to accommodate activities of daily living. I also certify that I will retain information sufficient to substantiate this certification and shall make that information available for Review at the department's request.

Signature X:_____ Date: _____/ _____/ _____

PLEASE CONTINUE TO BACK SIDE TO COMPLETE APPLICATION

PROJECT DESCRIPTION: _____

_____

_____

_____

_____

TOTAL PROJECT VALUATION: $_____

PERMIT FEE (to be filled out by CDD): $_____

Please complete an itemized list of the home adaptation improvements eligible under the Grant Program:

#	Item	Valuation*	#	Item	Valuation*
1			8		
2			9		
3			10		
4			11		
5			12		
6			13		
7			14		
				***** *Cost of labor and materials* **TOTAL VALUATION OF ADAPTATION IMPROVEMENTS**	
The following below to be filled out by CDD office					
				ADJUSTED VALUATION COST [Total Project Valuation – Total Valuation of Adaptation Improvements (up to $20,000 maximum)] =	
				REDUCED PERMIT FEE	

I, _____, certify that I have filled out this form in its entirety and that the valuation costs listed here represent a true and correct statement of the total cost of this project.

Signature_____ **Date** _____**/** _____**/** _____

CDD OFFICE USE ONLY

Permit No. _____

Eligibility Verification: ☐ **Legal ID** ☐ **DMV Placard** ☐ **Medical Provider's Letter** ☐ **Gross Annual Income**

Date of Approval: _____**/** _____**/** _____

Approved By: _____

Receipt No: _____ **Grant Contribution** (Permit Fee – Reduced Permit Fee) = $_____