STATE OF CONNECTICUT - OFFICE OF POLICY AND MANAGEMENT

PLEASE PRINT OR TYPE

M-35R rev. 06/07

APPLICATION FOR RENTER'S REBATE OF ELDERLY RENTERS AND TOTALLY DISABLED PERSONS

SEE INSTRUCTIONS AT ASSESSOR'S OR LOCAL SOCIAL SERVICES OFFICE

_____ RENTER

FILING PERIOD MAY 15 - SEPT. 15

1. NAME (Last)	(First)	(Middle Initial)	YOUR BIRTH DATE (MO. Day. Yr.) / /	YOUR SOCIAL SECURITY NO. - -
2. SPOUSE'S NAME (Last)	(First)	(Middle Initial)	SPOUSE'S BIRTH DATE (Mo. Day. Yr.) / /	SPOUSE'S 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: ☐ MARRIED ☐ UNMARRIED 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 PROOF REQUIRED CHECK HERE: ☐

IF APPLICANT IS TOTALLY DISABLED CURRENT PROOF REQUIRED: CHECK HERE: ☐

6. WHAT % OF RENT AND UTILITIES DO YOU PAY? (Husband and Wife are considered to be one (1) renter) %

7. TOTAL RENT AND UTILITIES YOU ACTUALLY PAID. $

8. DID OR WILL YOU FILE A FEDERAL TAX RETURN FOR LAST YEAR? ☐ - YES (Attach Copy) ☐ - 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? YES 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 Adjusted Gross income or its equivalent. Also includes, but is not limited to, wages, lottery winnings, taxable pensions, IRA's, interest, dividends and net rental income. 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 grants 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 X	Date signed (Mo. Day. Yr.) / /	APPLICANT'S OR AGENT'S PHONE NO. ( ) (INCL. AREA CODE)	AGENT'S RELATIONSHIP

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

☐ FULLYEAR-$ x.05 OR ☐ PART YEAR - $ X (No. of Months / 12) x.05 = $

15. Subtract Line 14 from Line 13. If zero or negative amount, there is no benefit. Enter -0- on Line $

16. Indicate table used: ☐ Unmarried ☐ Married

17. MAXIMUM CREDIT ALLOWED

A. FULL YEAR: amount per table OR B. PART YEAR: amount per table X (No. of Months/12) = $

18. Enter amount from 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: _____

SIGNATURE OF ASSESSOR OR MEMBER OF ASSESSOR'S STAFF	Date signed (Mo. Day.Yr.) / /

DISTRIBUTION: Original-Assessor

Please see the instructions at the Assessor's or local Social Services Office for appeal information.

RENTERS' REBATE PROGRAM REQUEST
FOR EXTENSION OF TIME TO FILE

Please complete the following information and return this letter, along with a letter from your doctor, to the Connecticut Office of Policy and Management at the address below.

APPLICANT NAME _____

ADDRESS _____

_____

TELEPHONE NUMBER (_____) _____-_____

I am requesting an extension of time to file for the Renters' Rebate Program. I was under a doctor's care during the designated filing period of April 1 through October 1 of this year.

Enclosed please find a letter of medical proof from my doctor.

The deadline for filing a Request for Extension of Time to File is December 15th.

_____ _____

Signature Date

Send to: Connecticut Office of Policy and Management
450 Capitol Avenue
MS#54GSU
Hartford, CT 06106-1379
Attention: Patrick Sullivan

updated 09/29/16