PLEASE PRINT OR TYPE STATE OF CONNECTICUT - OFFICE OF POLICY AND MANAGEMENT

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

M-35R Rev 02/2014

_____ **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 : ☐ MARRIED ☐ UNMARRIED ☐ CIVIL UNION ☐ 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**	**NURSING HOME** CHECK HERE: ☐	IFAPPLICANT IS TOTALLY DISABLED **CURRENT PROOF REQUIRED**	**TOTALLY DISABLED** 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 ACTUALLY PAID BY APPLICANT/APPLICANTS $

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 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 X	Date signed (Mo, Day, Yr) _____/_____/_____	APPLICANT'S OR AGENT'S PHONE NO. 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

☐ FULL YEAR - $ x.05 (OR) ☐ 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: ☐ 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 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.) _____/_____/_____

Distribution: Original – Assessor Copy – Applicant Copy - OPM