

ATHLONE TOWN COUNCIL
APPLICATION FOR REDUCTION IN DOMESTIC WAIVER/SERVICE CHARGES
YEAR 2005

All Questions must be fully answered

Name of Applicant:_____ Account No:_____

Address:_____ Marital Status:_____

Age:_____ 4. Occupations/Trade:_____ 5. Weekly Income: €_____

Name of owner of house (if not applicant):_____

Particulars of all persons normally resident in the household including applicant:

The income of each person must be certified (see over).

NAME	AGE	RELATION TO APPLICANT	INCOME	SOURCE

Details of income from sources other than those stated above, e.g. part-time work, letting of lands or house. Interest on moneys on deposit etc. If no income from other sources write "No other Income".

Special grounds on which relief is claimed _____

I hereby declare that the information provided in this application is true and correct in all respects and that I have not omitted or misrepresented any information which might affect my eligibility for reduction of charges. I authorise the Council to make such inquiries and from whatever sources they consider necessary to determine my application. I understand that an application which is found to be false in any material respect will automatically disqualify the applicant from receiving any reduction charges.

Signed:_____ Date:_____

FOR OFFICE USE ONLY

I certify that I have examined this application and confirm that to the best of my knowledge and belief the information provided is true and accurate.

Signed:_____

REVENUE COLLECTOR

CERTIFICATE OF INCOME

FORM 1 – CERTIFICATE OF INCOME FROM EMPLOYMENT:

I certify that _____ is employed by _____
(Name) (Name of Employer)

in the capacity of _____
{Position Held}

Date of Commencement of Employment: _____

Gross Wage per week: € _____ Tax paid weekly: € _____

Weekly Social Welfare Deduction: € _____ Nett pay: € _____

Date: _____ Signed: _____

Address: _____

FORM 2 – CERTIFICATE OF INCOME FROM SOCIAL WELFARE OR PENSION:

I hereby certify that _____ of _____
(Name) (Address)

is currently in receipt of the sum of € _____ per week in respect of

(Name of Benefit/Assistance)

Date from which this Benefit/Assistance has been paid _____

Date: _____ Signed: _____

Position held: _____

FOR OFFICE USE ONLY

Name: _____ Balance Outstanding: € _____

Address: _____

I recommend that the charges stand/be reduced by € _____

Account No.	Reference	Date	Amount
_____	Waiver	_____	€ _____

(Staff Officer) (Date)

Remarks: _____