

# Town of Huntington

## Department of Human Services

Office of Handicap Services

423 Park Avenue, Room 205 Huntington, New York 11743-6991  
(631) 446-3726 <http://www.huntingtonny.gov/snow-berm-removal>

### Application for Snow Berm Removal Program for Persons with Disabilities with Limited Income

This Program is designed to assist persons with disabilities with limited income and no other means of removing the snow berm at the end of their driveway.

**ALL APPLICATIONS MUST BE COMPLETE AND ACCOMPANIED BY THE FIRST TWO PAGES OF YOUR TAX RETURN FROM THE PREVIOUS YEAR. IF YOU DO NOT FILE A TAX RETURN, YOU MUST SEND A COPY OF YOUR NON-FILING VERIFICATION FROM THE INTERNAL REVENUE SERVICE (FORM 4506-T). INCOMPLETE APPLICATIONS WILL BE RETURNED.**

*First 2 Pages of your Tax Return From The Previous Year*

*Copy of Non-Filing Verification from the IRS [4506-T](#)*

Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Town \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_ Cell Number \_\_\_\_\_

Email \_\_\_\_\_ Disability \_\_\_\_\_

Do you rent \_\_\_\_\_ or own \_\_\_\_\_ your home?

Do you have any dependents? \_\_\_\_\_ If yes, how many? \_\_\_\_\_

Do you use a mobility aid (i.e.; wheelchair, cane, prosthesis)? Circle one YES NO

If YES, please specify which type \_\_\_\_\_

If you have a NYS Handicapped Parking Permit or Handicapped Symbol Access License Plate

Please provide the following: Permit # \_\_\_\_\_ License Plate # \_\_\_\_\_

Do you visit a Doctor, Hospital or Clinic on a Regular Basis? Circle one YES NO

If YES, how often? \_\_\_\_\_.

Please provide the following: Name, Address and Phone Number of your Physician:

DOCTOR'S NAME: \_\_\_\_\_

DOCTOR'S ADDRESS: \_\_\_\_\_

DOCTOR'S PHONE NUMBER: \_\_\_\_\_

Do you require life-sustaining treatment such as dialysis, use of a respirator or chemotherapy,...?

Yes

NO

(specify) \_\_\_\_\_

List all other persons residing at your address

NAME	AGE	REASON THEY CAN'T HELP WITH SNOW REMOVAL

I certify that my TOTAL GROSS YEARLY HOUSEHOLD INCOME  
(Including all persons residing in the house) is

\$ \_\_\_\_\_

I understand that the information provided on this application is to be used for the processing of my Snow Berm Application. I certify that all of the information on this application is true and that all statements are accurate under the penalty of perjury.

I fully authorize the Town of Huntington to verify any and all of the information contained herein.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please return the application to:

Town of Huntington  
Department of Human Services  
Office of Handicap Services  
423 Park Avenue, Room 205  
Huntington, New York 11743.

**You must apply each year for this program.**