City of Chiloquin, Oregon
Snow Angel Program
Disabled and Low-Income Statement

Address: _____

Name of Resident: _____

Name of Spouse: _____

LIST ALL OTHER RESIDENTS AT THIS ADDRESS AND THEIR AGES

Name

_____

_____

_____

_____

_____

_____

(Use the back of this sheet for any additional residents. We must have a Medical Disability Statement completed for each resident aged 18 and older.)

Total Annual Income for all residents at this address: Including but not limited to wages, salary, investments, social security, retirement, veteran's benefits, unemployment, workers comp, child support, inheritance:

$ _____ *Please note income guidelines attached.*

I declare that I have examined this application and to the best of my knowledge and belief, it is true, correct, and complete. I further declare that I am the principal resident of the above address. I will be advised if I am successfully registered for this program.

_____ _____

Signature Date

FY 2019 Income Limits Documentation System

FY 2019 Income Limits Summary

Selecting any of the buttons labeled "Explanation" will display detailed calculation steps for each of the various parameters.

FY 2019 Income Limit Area	Median Family Income Explanation	FY 2019 Income Limit Category	Persons in Family 1	2	3	4	5	6	7	8
Klamath County, OR	$51,400	Very Low (50%) Income Limits ($) Explanation	20,150	23,000	25,900	**28,750**	31,050	33,350	35,650	37,950
		Extremely Low Income Limits ($)* Explanation	12,490	16,910	21,330	**25,750**	30,170	33,350*	35,650*	37,950*
		Low (80%) Income Limits ($) Explanation	32,200	36,800	41,400	**46,000**	49,700	53,400	57,050	60,750

* The FY 2014 Consolidated Appropriations Act changed the definition of extremely low-income to be the greater of 30/50ths (60 percent) of the Section 8 very low-income limit or the poverty guideline as established by the Department of Health and Human Services (HHS), provided that this amount is not greater than the Section 8 50% very low-income limit. Consequently, the extremely low income limits may equal the very low (50%) income limits.

Income Limit areas are based on FY 2019 Fair Market Rent (FMR) areas. For information on FMRs, please see our associated FY 2019 Fair Market Rent documentation system.

For last year's Median Family Income and Income Limits, please see here:

FY2018 Median Family Income and Income Limits for Klamath County, OR

Select a different county or county equivalent in Oregon:

Klamath County
Lake County
Lane County

Select any FY2019 HUD Metropolitan FMR Area's Income Limits:

Abilene, TX MSA

City of Chiloquin, Oregon
Snow Angel Program

WAIVER OF LIABILITY

The undersigned person is the principal resident at the residence located at _____ within the city limits of the City of Chiloquin.

The undersigned person has provided a completed Snow Angel application, along with any and all required documentation.

In consideration of the Snow Angel Volunteer performance of snow removal of the berm at the above residence, the undersigned agrees to indemnify, defend, hold harmless and release the City, its officers, agents and employees, as well as the Snow Angel Volunteers, from and against any and all loss, liability, personal injury, property damage, claims, costs and expenses, including attorneys' fees, which may be incurred directly or indirectly as a result of the Snow Angel Program , and agrees not to sue the City, any member of its Public Works Department, or any other City officers, agents or employees, as well as the Snow Angel Volunteers for any such injury, loss or damage which may be suffered by the undersigned by any reason other than by negligence of the City, and member of its Public Works Department, or any other City officers, agents or employees, as well as the Snow Angel Volunteers.

Nothing herein contained shall confer any rights on the undersigned or any third party or on the heirs or personal representatives of the undersigned.

The City reserves the right to manage, revise or terminate the Snow Angel Program at any time and for any reason that it deems sufficient.

This waiver shall be binding on and inure to the benefit of the heirs, executors, administrators, successors and assign of the respective parties hereto.

_____ _____

Signature Printed Name

_____

Date

City of Chiloquin, Oregon
Snow Angel Program
Medical Disability Statement
(To be filled out by your physician)

Date_____ Patient Name: _____

- I attest that this patient has a permanent disability that prevents him/her from shoveling snow.

- I attest that this patient has a temporary disability that prevents him/her from shoveling snow for this snow season.

_____

Physician Signature

_____

Physician Name

(Please Print)

Physicians, please staple a prescription sheet from your office to this form.