Wicomico County Health Department
108 E. Main St., Salisbury, Maryland 21801
(410)546-4446 Fax (410)219-2882

Property ID #: ______________________

Application Date: ___________________

BAY RESTORATION FUND

APPLICATION FOR FINANCIAL ASSISTANCE FOR AN OSDS PRE-TREATMENT UNIT

Property Owner: ____
Mailing Address: ____
____
Telephone: ______________________ Telephone: ______________________
Email Address: ____
Location of Property: ____
Tax Map: ____________ Grid: ____________ **Parcel:** ____________ Size: ____________
Subdivision: ______________________ Section: __________ Block: ________ Lot: ________
Pretreatment unit is for: (**select all that apply and fill in the blanks)-Total # of bedrooms:** __________

- ☐ A failing sewage system serving a residence with ____ bedrooms.
- ☐ New construction _____ # of bedrooms or ________ gallons per day (gpd) projected wastewater flow (commercial).
- ☐ A property located in the Chesapeake Critical Area.
- ☐ A property within 500' of shellfish waters or a bathing beach.
- ☐ A property which is inadequate for a conventional on-site sewage system for which a groundwater penetration is proposed.
- ☐ A property with an OSDS serving multiple dwelling units or commercial units.
- ☐ A commercial building (include use, hours of operation, number of employees, square footage, construction plans on letterhead).
- ☐ A property served by a large system (over 5,000 gpd).
- ☐ Other – Specify: ____.

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Owners Statement

I grant permission for the Health Department personnel to enter my property to perform necessary field work, inspections, etc. and indemnify the department from any claims arising there from. I understand that 1) I am applying to participate in a program to investigate the use of pre-treatment technology and that I must properly maintain the pre-treatment unit once it is installed; 2) this program and financial assistance applies to the cost of engineering, inspection, 5 years of maintenance, and the cost associated with only the pre-treatment component of the sewage system; all other expenses are the responsibility of the property owner; 3) the Health Departments approval of a pre-treatment unit does imply a guarantee; 4) a signed pre-treatment agreement is required and must be recorded in the land records; and 4) that completion of this application does not imply approval or availability of funds to the applicant.

Owner's Signature: ______________________________ Date: ________________

Owner's Name (printed): ____

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Dept. Use:
Area Sanitarian: __________________ GPR Zone: __________ Soil Type(s): ______________
Permit Number: __________ Type of BAT proposed: ______________ Manufacturer: __________
☐ Nutrient Reduction: ____________________ ☐ Pathogen Reduction ____________________
Pre-installation meeting date: ________ with: ________ ☐ Peat ☐ UV ☐ Chlorination ☐ Other: ________
Inspection Date: ____________ Inspector: ____________ Coordinates: N - ________ E - ________
Date certification received from manufacturer: ______________________________________
Management Entity: ______________________ Sampling Schedule: ______________________
Additional Comments: ____
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