## ELDERLY/TOTALLY DISABLED HOMEOWNERS' PROGRAM

## REQUEST FOR EXTENSION OF TIME TO FILE

Please complete the following information and return this letter, <u>along with a letter from your doctor</u>, to the Secretary, Connecticut Office of Policy and Management at the address below.

APPLICA	NT NAME			
ADDRESS	5			
			ZIP_	
TELEPHO	NE NUMBER (_	)	<del>-</del>	
Homeowne	_	as under a doo	ctor's care du	erly/Totally Disabled tring the designated
Enclosed p	olease find a lette	r of medical	proof from 1	my doctor.
The statuto August 15 <sup>th</sup>	_	ing a Request	for Extensio	on of Time to File is
Signature			_	Date
Send to:	Connecticut Off 450 Capitol Ave MS#54GSU Hartford, CT 06 Attn: Patrick Su	enue 5106-1379	and Managei	ment  updated 01/28/13