BERKS COUNTY TAX CLAIM BUREAU
HARDSHIP AGREEMENT

PURPOSE

Pursuant to the subsection 5033 (a) of the Real Estate Tax Sale Law of July 7, 1947, P.L. 1368, as amended, 72 P.S. 5860.101, et seq., if a tax claim constitutes severe hardship to the taxpayer and that extenuating circumstances beyond taxpayer's control have caused the tax claim to remain unpaid and there is reasonable probability that the taxpayer will be able to meet the indebtedness, if granted an extension of the period for discharge of the tax claim for up to twelve (12) additional months.

ELIGIBILITY

- Taxpayer must be a permanent resident of the Commonwealth of Pennsylvania
- The property which the tax claim is against is owner-occupied
- Taxpayer must have one (1) of the following extenuating circumstances:
    - HEALTH-RELATED ISSUE: Serious physical illness or injury or a combination of the illness or injury with a state of prolonged unemployment
    - PROLONGED UNEMPLOYMENT: Actively eligible and receiving unemployment from the Commonwealth of Pennsylvania Department of Labor and Industry

PROGRAM INSTRUCTIONS

In order to be considered for the program, the taxpayer must:

- Fill out the Hardship Application in its entirety and supply the supporting documentation
    - Authorization for Disclosure of Healthcare and Attending Physician Statement
    - Notice of Financial Determination from the Pennsylvania Department of Labor and Industry

All documentation should be sent to:

BERKS COUNTY TAX CLAIM BUREAU
ATTN: HARDSHIP PROGRAM
633 COURT STREET, 2ND FLOOR
READING, PA 19601

Within thirty (30) days of receipt of the completed Application and Form(s), the Tax Claim Bureau will notify the taxpayer in writing, of the eligibility determination for the Hardship Program. If granted, all unpaid delinquent taxes owed will be combined and the taxpayer will be required to make an initial payment of at least ten percent (10%) to initiate the agreement. The remainder of the agreement balance will be paid over the course of twenty-three (23) payments.

BERKS COUNTY TAX CLAIM BUREAU
HARDSHIP AGREEMENT APPLICATION

DATE		PIN	
PROPERTY LOCATION			
OWNER NAME(S)			
MAILING ADDRESS			
PHONE #		EMAIL	

DO YOU OWN THE PROPERTY LOCATION LISTED ABOVE?	YES	NO
DO YOU RESIDE AT THE PROPERTY LOCATION LISTED ABOVE?	YES	NO

WHAT HARDSHIP ARE YOU EXPERIENCING TO BE ELIGIBLE FOR THIS AGREEMENT?	HEALTH-RELATED ISSUE	PROLONGED UNEMPLOYMENT

If you are applying for the Hardship Agreement due to a **HEALTH-RELATED ISSUE**, please complete this section and have your health care provider complete the attached form to be returned with your application for review.

• Are You a permanent resident of the Commonwealth of Pennsylvania?	YES	NO
• Has the illness/injury occurred or persisted during the tax year(s) for which the delinquent taxes were assessed or during the year immediately preceding any such delinquency?	YES	NO
• Has the illness/injury been a substantial cause of your failure to pay any such delinquent taxes to date?	YES	NO

If you are applying for the Hardship Agreement due to **PROLONGED UNEMPLOYMENT**, please complete this section and be sure to include a copy of your Notice of Financial Determination Form (UC-44F) from the Pennsylvania Department of Labor and the most recent pay period you were eligible to claim.

• Are You a permanent resident of the Commonwealth of Pennsylvania?	YES	NO
• Has your unemployment occurred or persisted during the tax year(s) for which the delinquent taxes were assessed or during the year immediately preceding any such delinquency?	YES	NO
• Has your unemployment been a substantial cause of your failure to pay any such delinquent taxes to date?	YES	NO

I, _____ (printed applicant name) verify that the facts set forth in the foregoing are true and correct, to the best of my knowledge, information and belief. I understand that the statements contained herein are made subject to penalties jof 18 PA C.S.A Section 4904 relating to unsworn falsification to authorities.

Applicant's Signature_____ Date_____

RETURN APPLICATION AND SUPPORTING DOCUMENTATION TO: BERKS COUNTY TAX CLAIM BUREAU, ATTN: HARDSHIP APPLICATION, 633 COURT STREET, 2ND FLOOR, READING, PA 19601

Rev. 06/2021

Authorization for Disclosure of Healthcare Information

I hereby authorize _____ (physician's name) to release to the Berks County Tax Claim Bureau the Attending Physician Statement attached hereto. This Statement will be submitted to the Berks County Treasurer as part of my application to participate in the County's Hardship Program for the deferred payment of my delinquent real estate taxes.

I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS SPECIFIED ABOVE. I UNDERSTAND THAT THE INFORMATION DISCLOSED ACCORDING TO THIS AUTHORIZATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY LAW AND THE RECIPIENT OF MY HEALTH INFORMATION MAY POTENTIALLY REDISCLOSE IT. THIS AUTHORIZATION WILL BE VALID FOR 180 DAYS ONLY. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, BY NOTIFYING THE PRIVACY CONTACT FOR THE PROVIDER THAT THIS REQUEST IS DIRECTED TO AND THE COUNTY TREASURER OF THE COUNTY OF BERKS, PENNSYLVANIA. THE EXCEPTION TO MY RIGHT TO REVOKE INCLUDES DISCLOSURES THAT WERE MADE PRIOR TO MY REVOCATION AND ANY AUTHORIZATION THAT WAS OBTAINED AS A CONDITION OF OBTAINING INSURANCE COVERAGE. I AUTHORIZE THAT A PHOTOCOPY OF THIS AUTHORIZATION BE ACCEPTED IN LIEU OF THE ORIGINAL.

Date: _____ Signature: _____

Guardian or Legal Representative: _____

Printed Name of Representative: _____

Date: _____

COUNTY OF BERKS ATTENDING PHYSICIAN STATEMENT

1. PATIENT INFORMATION

Name: **Birth Date:**

Address:

2. TREATMENT INFORMATION

Primary Diagnosis:

Are you currently treating this patient?

Date first treated for this condition: **Date of patient's last visit:**

3. PROGRESS

Patient has:	**Recovered**	_____	**Not Changed**	_____
	Improved	_____	**Retrogressed**	_____
			Other	_____
Patient is:	**Ambulatory**	_____	**House Confined**	_____
	Bed Confined	_____	**Hospital Confined**	_____
			Other	_____

Have you placed patient on a "off-work" status? ___ **Yes** ___ **No**
If yes, what date? ____/____/____

If patient is not released to return to work, when do you anticipate a release? ____/____/____

4. PHYSICIAN INFORMATION

Physician's Name:
Office Address:

Telephone #: **Fax#**

Degree/Speciality:

I, _____, (Physician Name) verify that the facts set forth in the foregoing are true and correct, to the best of my knowledge, information, and belief. I understand that the statements contained herein are made subject to the penalties of 18 PA C.S.A. Section 4904 relating to unsworn falsification to authorities.

_____ ____/____/____
Physician Signature Date

PLEASE RETURN THIS COMPLETED FROM TO: PATIENT OR BERKS COUNTY TAX CLAIM, HARDSHIP PROGRAM, 633 COURT STREET, 2ND FL, READING, PA 19601
TELEPHONE (610-478-6625)