Town of Washington

Building Department
10 Reservoir Drive • P.O Box 667
Millbrook, NY 12545
(845) 677-3419 EXT 112 • buildinginspector@washingtonny.org

Application for Building Permit

This application must be completely filled out with ink and submitted to the Building Office at the Town of Washington Town Hall. To be submitted along with this application:

1. Two complete plans of the proposed construction, showing materials and equipment to be used, and the details of structural, mechanical, plumbing, electrical, and Energy Code Compliance, as applicable. The Building Inspector may require that these plans be stamped and signed by a New York State registered architect or engineer.
2. A plot plan showing the proposed construction in relation to the property line boundaries, existing structures, and wetlands, if applicable.
3. Owner's Authorization Form and Insurance information as required, see below.

Applicant: Name Peter Dawson
Address: 1 Hollow Lane Poughkeepsie NY 12603 Phone: 9147607383
Email: MCPD99@Gmail.Com

Property Owner: Name: Corey Mann
Address 452 Hibernia Road Phone: 646-645-6431
Signed and Notarized Owner's Authorization Form Attached **OR** ☐Property Owner same as Applicant

Property: Address: 452 Hibernia Rd Salt Point NY 12578
Tax Grid ID Number: 135889 6566 00 697093 0000 Zoning District: 210 / Family Res
Is the proposed project located in a wetland or 100 year flood plain? No

Proposed Work: Setbacks from property line: Front 132.8, Rear 208, Side 1 63.4, Side 2 208.75 ☐
New Building ☒Addition ☐Alteration/Renovation ☐Repair ☐Installation(HVAC, etc) ☐Demolition ☐Retroactive C/O
☐Swimming Pool/Hot Tub ☐Fireplace/Wood/Pellet Stove ☐Roofing/Siding ☐Deck ☐Tent >400FT² ☐Agricultural
☐Propane Tank ☐Shed or Barn ☐Solar ☐Other (please specify) Front Porch
Builder's Name: Mastercraft Contracting & Remodeling Inc Phone: 9147607383
Builder's Address: 1 Hollow Lane, Poughkeepsie NY 12603
Builder's Email: MCPD99@Gmail.Com

Builders must provide proof of Workers Compensation Insurance (C105.2 or U26.3) and proof of Disability Benefits Compensation (DB120.1) Homeowners or Sole Proprietors may provide CE-200 Certificate of Attestation of Exemption. ☒Builder's Insurance Information attached ☐ Exemption Form Attached

Estimated Cost of Project: 40,000 Description of Proposed Work (include square footage as applicable):
New Front Covered Porch

Please read, initial, and sign page 2.

Town of Washington

Application for Building Permit

I hereby certify that I have read, do understand, and will comply with the following: (Please read, initial each, then sign)

1. The work covered by this application may not be commenced before the issuance of a Building Permit. Work begun prior to the issuance of a Building Permit will be subject to an additional fee of 55%. M
2. Building Permits shall be visibly displayed at the work site and remain visible until the project has been completed. M
3. All work shall be performed in accordance with the construction documents submitted and accepted as part of the application. The Building Inspector shall be notified immediately in the event of changes occurring during construction. M
4. A building permit becomes void if the work is not started within 180 days of issue. Building permits expire 1 year after issue, and may be renewed for up to (2) 6 month periods, renewal fee is 55% of the original fee. M
5. The applicant agrees to comply with all applicable State and Town laws, ordinances and regulations. M
6. Work shall remain accessible and exposed until inspected and accepted by the Building Inspector, and it is the responsibility of the applicant to schedule all required inspections. M
7. No structure or improvement may be occupied or used in whole or in part for any purpose whatsoever until a Certificate of Occupancy or Certificate of Compliance has been issued. M
8. The applicant does hereby give consent to representatives of the Town of Washington, including, but not limited to the Building Inspector, Zoning Administrator or Assessor to conduct such inspections as they deem necessary in relation to this building permit application, date and time of inspections to be scheduled in advance with the property owner or their representative. Assessor inventory verification to include ground & aerial photography M

Applicant: _____ Date: 11/6/25
SIGNATURE

Building Inspector: _____ Date: _____

FOR OFFICE USE ONLY: Permit Number: _____ Permit Fee: _____ Check Number: _____

▫Zoning Approval ▫No Open Permits or Violations ▫Insurance ▫Plans and Site Plan ▫Plan Review

Reason if Denied/Referred: DOES NOT MEET SETBACKS

Type of Construction: **I II III IV V A B** Use and Occupancy Classification: _____

Assembly Occupant Load: _____ Automatic Sprinkler System: **Y N** Required: **Y N**

Bedrooms: ____ # Bathrooms: ____ # Kitchens: ____ Basement Type: _____ Finished: **Y N** Sq Ft: _____

Walls: _____ Siding: _____ Roof: _____ Finished Attic: **Y N**

Insulation: Ceiling _____ Walls: _____ Floor: _____ Slab: _____ Foundation: _____

Washington

TOWN OF WASHINGTON
BUILDING DEPARTMENT
10 Reservoir Dr, PO Box 667
Millbrook, NY 12545
845-677-3419

THIS DOCUMENT MUST BE SIGNED BEFORE A NOTARY PUBLIC

PLEASE NOTE: If ownership is held by a corporation, LLC, jointly or in partnership, each owner and/or partner must sign a separate owner's endorsement.

OWNER'S ENDORSEMENT

STATE OF NEW YORK)
COUNTY OF DUTCHESS) ss:

Corey Moran, *being duly sworn, deposes and says:*

I am: (check one)

- ✓ 1. the sole owner in fee (One individual on the tax roll)
- ____ 2. a part owner in fee (Two or more individuals on the tax roll)
- ____ 3. an officer of the corporation which is the owner in fee of the premises described in the foregoing application.
- ____ 4. designated party authorized to act pursuant to a trust or legal document. (Trustees listed on tax roll)
- ____ 5. member/owner(s) of Limited Liability Corporation (LLC).

(If you checked #3, #4 or #5, you must attach proof of authority (i.e.: Corporate Resolution, Surrogate Letter, Executor of the Will, Certified Letter of Testamentary, Letter of Administration, Attorney-Opinion Letter, Letter or Probate, Power of Attorney)

I reside at 452 Hibernia Rd
City Salt Point State NY Zip 12578

I have authorized (name) Peter Donwa

(Company) Mastercraft Contracting and Remodeling Inc.
to make the foregoing application to the Town of Washington for approval as described herein for the property located at 452 Hibernia Rd, Salt Point, NY 12578
property ID # 135889-6566-697073-0000.

Signature

If owner is a corporation or LLC, please indicate name of the entity and title of the officer whose signature appears above.

Sworn to before me this
7 day of November, 2025.
Notary Public Kathie G. Vasquez
My commission expires: Oct 9, 2028

Notary Stamp:

KATHIE G. VASQUEZ
Notary Public - State of New York
No.01VA0029710
Qualified in Orange County
My Commission Expires Oct. 09, 2028

____ Proof of Authority is attached.
____Corporate Resolution, ____LLC Formation, ____Surrogate Letter, ____Executor of a Will,
____Certified Letter of Testamentary, ____ Letter of Administration, ____ Letter of Probate,
____Power of Attorney

NYSIF
New York State Insurance Fund

PO Box 66699, Albany, NY 12206
| nysif.com

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

^^^^^^ 134024421
LEVITT-FUIRST ASSOCIATES LTD
520 WHITE PLAINS ROAD, 2ND FL
TARRYTOWN NY 10591

SCAN TO VALIDATE
AND SUBSCRIBE

POLICYHOLDER	CERTIFICATE HOLDER
MASTERCRAFT CONTRACTING & REMODELING INC. 1 HOLLOW LANE POUGHKEEPSIE NY 12603	TOWN OF WASHINGTON BUILDING DEPARTMENT 10 RESERVOIR DRIVE PO BOX 667 MILLBROOK NY 12545

POLICY NUMBER	CERTIFICATE NUMBER	POLICY PERIOD	DATE
G2178 850-0	15862	06/29/2025 TO 06/29/2026	11/6/2025

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 2178 850-0, COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW.

IF YOU WISH TO RECEIVE NOTIFICATIONS REGARDING SAID POLICY, INCLUDING ANY NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE THIS CERTIFICATE, VISIT OUR WEBSITE AT HTTPS://WWW.NYSIF.COM/CERT/CERTVAL.ASP. THE NEW YORK STATE INSURANCE FUND IS NOT LIABLE IN THE EVENT OF FAILURE TO GIVE SUCH NOTIFICATIONS.

THIS POLICY DOES NOT COVER CLAIMS OR SUITS THAT ARISE FROM BODILY INJURY SUFFERED BY THE OFFICERS OF THE INSURED CORPORATION.

PETER DONOVAN- PRES
MASTERCRAFT CONTRACTING &
REMODELING INC
1 OF 1

THE POLICY INCLUDES A WAIVER OF SUBROGATION ENDORSEMENT UNDER WHICH NYSIF AGREES TO WAIVE ITS RIGHT OF SUBROGATION TO BRING AN ACTION AGAINST THE CERTIFICATE HOLDER TO RECOVER AMOUNTS WE PAID IN WORKERS' COMPENSATION AND/OR MEDICAL BENEFITS TO OR ON BEHALF OF AN EMPLOYEE OF OUR INSURED IN THE EVENT THAT, PRIOR TO THE DATE OF THE ACCIDENT, THE CERTIFICATE HOLDER HAS ENTERED INTO A WRITTEN CONTRACT WITH OUR INSURED THAT REQUIRES THAT SUCH RIGHT OF SUBROGATION BE WAIVED.

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

NEW YORK STATE INSURANCE FUND

DIRECTOR,INSURANCE FUND UNDERWRITING

VALIDATION NUMBER: 1019534823

U-26.3

MASTCON-15 GGOWDA

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 11/6/2025

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Acrisure Insurance Partners Services of NY, LLC
90 S. Ridge Street
Rye Brook, NY 10573

CONTACT NAME: Diane Powell
PHONE (A/C, No, Ext): (332) 242-2460 FAX (A/C, No):
E-MAIL ADDRESS: DAPowell@acrisure.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : CUMIS Specialty Insurance Company, Inc.	12758
INSURER B : Merchants Mutual Insurance Company	23329
INSURER C : Century Surety Company	36951
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Mastercraft Contracting & Remodeling, Inc.
1 Hollow Lane
Poughkeepsie, NY 12603

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE / X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / X LOC OTHER:	X		PGIA00290-01	8/24/2025	8/24/2026	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 100,000 $ 5,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
B	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY / SCHEDULED AUTOS HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY			CAPI079227	6/8/2025	6/8/2026	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
C	UMBRELLA LIAB / X OCCUR X EXCESS LIAB / CLAIMS-MADE DED / RETENTION $			CCP13119242	8/24/2025	8/24/2026	EACH OCCURRENCE AGGREGATE	$ 3,000,000 $ 3,000,000
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N If yes, describe under DESCRIPTION OF OPERATIONS below	N / A					PER STATUTE / OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $ $

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
TOWN OF WASHINGTON IS LISTED AS ADDITIONAL INSURED ON THE GENERAL LIABILITY AS REQUIRED BY WRITTEN CONTRACT OR AGREEMENT; SUBJECT TO THE POLICY TERMS AND CONDITIONS.

CERTIFICATE HOLDER
TOWN OF WASHINGTON
BUILDING DEPARTMENT
10 RESERVOIR DRIVE
P.O BOX 667
MILLBROOK, NY 12545

CANCELLATION
SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
LB

ACORD 25 (2016/03)

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF INSURANCE COVERAGE

NYS DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

PART 1. To be completed by NYS disability and Paid Family Leave benefits carrier or licensed insurance agent of that carrier

1a. Legal Name & Address of Insured (use street address only)
MASTERCRAFT CONTRACTING AND REMODELING, INC.
1 HOLLOW LANE
POUGHKEEPSIE, NY 12603

1b. Business Telephone Number of Insured
845-463-2234

1c. Federal Employer Identification Number of Insured or Social Security Number
134024421

Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)*

2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)
TOWN OF WASHINGTON
BUILDING DEPARTMENT
10 RESERVOIR DRIVE, P.O BOX 667
MILLBROOK, NY 12545

3a. Name of Insurance Carrier
ShelterPoint Life Insurance Company

3b. Policy Number of Entity Listed in Box "1a"
DBL423273

3c. Policy effective period
01/01/2025 to 12/31/2026

4. Policy provides the following benefits:
- [x] A. Both disability and paid family leave benefits.
- [ ] B. Disability benefits only.
- [ ] C. Paid family leave benefits only.

5. Policy covers:
- [x] A. All of the employer's employees eligible under the NYS Disability and Paid Family Leave Benefits Law.
- [ ] B. Only the following class or classes of employer's employees:

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has NYS Disability and/or Paid Family Leave Benefits insurance coverage as described above.

Date Signed 11/6/2025 By _____
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number 516-829-8100 Name and Title Wade Harrison, President

IMPORTANT: If Boxes 4A and 5A are checked, and this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent of that carrier, this certificate is COMPLETE. Mail it directly to the certificate holder.

If Box 4B, 4C or 5B is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the NYS Disability and Paid Family Leave Benefits Law. It must be emailed to PAU@wcb.ny.gov or it can be mailed for completion to the Workers' Compensation Board, Plans Acceptance Unit, PO Box 5200, Binghamton, NY 13902-5200.

PART 2. To be completed by the NYS Workers' Compensation Board (Only if Box 4B, 4C or 5B have been checked)

State of New York
Workers' Compensation Board

According to information maintained by the NYS Workers' Compensation Board, the above-named employer has complied with the NYS Disability and Paid Family Leave Benefits Law(Article 9 of the Workers' Compensation Law) with respect to all of their employees.

Date Signed _____ By _____
(Signature of Authorized NYS Workers' Compensation Board Employee)

Telephone Number _____ Name and Title _____

Please Note: *Only insurance carriers licensed to write NYS disability and paid family leave benefits insurance policies and NYS licensed insurance agents of those insurance carriers are authorized to issue Form DB-120.1.* ***Insurance brokers are NOT authorized to issue this form.***

DB-120.1 (12-21)

Additional Instructions for Form DB-120.1

By signing this form, the insurance carrier identified in Box 3 on this form is certifying that it is insuring the business referenced in Box 1a for disability and/or Paid Family Leave benefits under the NYS Disability and Paid Family Leave Benefits Law. The insurance carrier or its licensed agent will send this Certificate of Insurance Coverage (Certificate) to the entity listed as the certificate holder in Box 2.

The insurance carrier must notify the above certificate holder and the Workers' Compensation Board within 10 days IF a policy is cancelled due to nonpayment of premiums or within 30 days IF there are reasons other than nonpayment of premiums that cancel the policy or eliminate the insured from coverage indicated on this Certificate. (These notices may be sent by regular mail.) Otherwise, this Certificate is valid for one year after this form is approved by the insurance carrier or its licensed agent, or until the policy expiration date listed in Box 3c, whichever is earlier.

This Certificate is issued as a matter of information only and confers no rights upon the certificate holder. This Certificate does not amend, extend or alter the coverage afforded by the policy listed, nor does it confer any rights or responsibilities beyond those contained in the referenced policy.

This Certificate may be used as evidence of a NYS disability and/or Paid Family Leave benefits contract of insurance only while the underlying policy is in effect.

Please Note: Upon the cancellation of the disability and/or Paid Family Leave benefits policy indicated on this form, if the business continues to be named on a permit, license or contract issued by a certificate holder, the business must provide that certificate holder with a new Certificate of Insurance Coverage for NYS disability and/or Paid Family Leave Benefits or other authorized proof that the business is complying with the mandatory coverage requirements of the NYS Disability and Paid Family Leave Benefits Law.

NYS DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

§220. Subd. 8

(a) The head of a state or municipal department, board, commission or office authorized or required by law to issue any permit for or in connection with any work involving the employment of employees in employment as defined in this article, and not withstanding any general or special statute requiring or authorizing the issue of such permits, shall not issue such permit unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits and after January first, two thousand and twenty-one, the payment of family leave benefits for all employees has been secured as provided by this article. Nothing herein, however, shall be construed as creating any liability on the part of such state or municipal department, board, commission or office to pay any disability benefits to any such employee if so employed.

(b) The head of a state or municipal department, board, commission or office authorized or required by law to enter into any contract for or in connection with any work involving the employment of employees in employment as defined in this article and notwithstanding any general or special statute requiring or authorizing any such contract, shall not enter into any such contract unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits and after January first, two thousand eighteen, the payment of family leave benefits for all employees has been secured as provided by this article.