Your application for Low Income Home Energy Assistance (LIHEAP) AND Low Income Home Water Assistance Program (LIHWAP) will not be processed without the proper documentation. Please make sure your application is complete prior to submitting it to K’ima:w Medical Center staff. Please use the checklist below.

If you are disabled or have a medical condition that requires a specific energy need, you must provide supporting documentation. All disabilities must be in accordance with State Disability or the Social Security Administration guidelines.

LIHEAP Application Checklist

_____ Completed Application

_____ Proof of Income for all Household members

_____ Current Energy/Utility Bills
  [  ] PG&E Bill  [  ] Campora/Amerigas  [  ] Jury’s  [   ] Valley Pacific
  [   ] HVPUD Water Bill  [   ] Other _________

_____ Proof of Physical Address

_____ Proof of Tribal Verification

_____ Proof of Handicap/Disability (only if claiming Disability)

_____ Zero Income Verification (only if claiming Zero Income)

OFFICE USE ONLY:

Applicant Name:__________________________________________________________

Submitted on:_____________    Received By:________________________
LIHEAP/LIHWAP Application Form 2022-2023

Applicant Information

<table>
<thead>
<tr>
<th>FIRST NAME</th>
<th>MIDDLE</th>
<th>LAST NAME</th>
<th>SUFFIX</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADDRESS (PO BOX)</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PHYSICAL ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- - -  ( ) -
SOCIAL SECURITY NUMBER PHONE # DATE OF BIRTH

HOOPA VALLEY TRIBAL MEMBER:  YES  NO  ROLL # ____________
(PLEASE ATTACH A COPY OF TRIBAL VERIFICATION)

Additional Household Members (list all residents of household)

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Disabled</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Energy Assistance Request

Please circle ONE (1) of the following vendors you are requesting assistance for:

- PG&E
- CAMPORA
- AMERIGAS
- JURY’S
- VALLEY PACIFIC

OTHER_____________________________________________________

Do you have a shut-off notice from PG&E or has your service been disconnected OR do you have less than 10% or completely out of propane or kerosene?  YES  NO
(If yes, please provide proof such as a photo of a meter or current PG&E bill with shut-off notice.)
Water/Septic Assistance Request

Please circle ONE (1) of the following vendors you are requesting assistance for:

<table>
<thead>
<tr>
<th>WATER</th>
<th>EMERGENCY SEPTIC PUMP</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>HVPUD</td>
<td>Whitsons</td>
<td></td>
</tr>
</tbody>
</table>

Do you have a shut-off notice or has your service been disconnected?  YES  NO
(If yes, please provide the shut-off notice from HVPUD.)

Income Verification
(Please list the name and amount of monthly income. All income verification must be attached.)

<table>
<thead>
<tr>
<th>Name of each person with income in the household:</th>
<th>TANF/CAL-WORKS</th>
<th>SSA</th>
<th>SSI</th>
<th>EMPLOYMENT</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>EX: JANE DOE</td>
<td></td>
<td></td>
<td>$900</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL HOUSEHOLD INCOME  $

I hereby authorize K'ima:w Medical Center - An Entity of the Hoopa Valley Tribe's LIHEAP representative to examine and verify all information submitted for my application for payment under the LIHEAP Program. I hereby authorize my utility supplier(s) to release information on my account (past and future) to the above named LIHEAP program. I understand that this information is confidential. No information obtained through this release shall be made public so that the dwelling or occupants may be identified. I understand that my application will not be processed unless all required documentation is submitted. I also certify that the above information is true and correct to the best of my knowledge.

Applicant Signature ___________________________ Date ___________________________
ZERO INCOME VERIFICATION

The zero income form must be completed for every adult household member that is 18 years and older that is claiming zero income on the LIHEAP/LIHWAP application.

I, _______________________________, hereby certify that I had zero income for the year.

Please list the name/resource of how you were provided with the following:

1. Housing: (Where did you live/who provided housing/etc)
   _______________________________________________________________

2. Food: (Did you receive food-stamps/commodities/etc)
   _______________________________________________________________

3. Utilities: _______________________________________________________

4. Medical: _______________________________________________________

5. Transportation: ________________________________________________

6. Clothing: _____________________________________________________

7. Comments: (or you may provide further information regarding living and/or income status, or explain your zero income situation more thoroughly)
   __________________________________________________________________
   __________________________________________________________________

By signing this document I am certifying that all information provided orally and on this application form is true to the best of my knowledge. I acknowledge that such information is subject to verification and that falsification of this information shall be grounds for termination from any program in which I participate and that I may be subject to prosecution under the law. I further give permission for K’ima:w Medical Center - An Entity of the Hoopa Valley Tribe to verify the above statements with County Welfare, Unemployment or any other services agencies.

____________________________________ ______________________________
Applicant Signature Date
PROOF OF ENERGY BURDEN

Please list your monthly energy expenses. You need to provide proof of each expense that you are claiming. For example, if you are claiming you pay $100.00 for propane per month, you need to provide a copy of your propane bill. By providing this information, you may qualify for a higher amount of funding.

<table>
<thead>
<tr>
<th>Energy Source:</th>
<th>Current Monthly Expense (if any):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 WOOD</td>
<td></td>
</tr>
<tr>
<td>2 PROPANE</td>
<td></td>
</tr>
<tr>
<td>3 KEROSENE</td>
<td></td>
</tr>
<tr>
<td>4 ELECTRICITY</td>
<td></td>
</tr>
</tbody>
</table>

**Office Use Only:**

<table>
<thead>
<tr>
<th>Total Monthly Expenses:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Divide by Total Monthly Income</td>
<td></td>
</tr>
<tr>
<td>Energy Burden %</td>
<td></td>
</tr>
</tbody>
</table>

***An energy burden is your total energy expenses for one month (or year) divided by your monthly (or annual) income. For example: if your monthly income was $1000 and your electricity bill was $100, your propane, $100 and your kerosene $200 for one month then your total energy burden would be $400 for that month. $400 divided by $1000 is .40, which is equal to 40%.

I certify that the information I have provided is true and correct to the best of my knowledge. I am aware that willfully and knowingly falsifying information may lead to criminal prosecution and termination of services from K’ima:w Medical Center - An Entity of the Hoopa Valley Tribe's LIHEAP Program. I hereby authorize K’ima:w Medical Center's LIHEAP representative to examine and verify all information submitted for my application for payment under the LIHEAP Program. I hereby authorize my utility supplier(s) to release information on my account (past and future) to the above named LIHEAP program. I understand that this information is confidential. No information obtained through this release shall be made public so that the dwelling or occupants may be identified. I understand that my application will not be processed unless all required documentation is submitted.

_________________________________________  ________________________
Applicant’s Signature                      Date
~ CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION ~

I, ________________________________, hereby authorize and request that K'ima:w Medical Center's LIHEAP Program may release and/or exchange all confidential professional information pertaining to me (or my minor children) to the following individuals and agencies:

☐ All Courts (Tribal, Federal, State, & County)
☐ TANF: ________________________________
☐ Social Services/DHS (Local & County)_____________________
☐ ICW/CWS/CPS: ________________________________
☐ Housing Authority: ________________________________
☐ Education/School: ________________________________
☐ Employment Development Department_____________________
☐ K'ima:w Medical Center: ______________________________
☐ Other Medical Facilities: ______________________________
☐ Other: ________________________________

I understand that this Release of Information will remain in effect for one (1) year and that I may revoke this consent at any time by informing the above parties in writing. My signature below indicates I have read and thoroughly understand the terms of this consent for release of confidential information. By signing this Consent for Release of Information I hereby release K'ima:w Medical Center's LIHEAP Program and its agents and employees from any and all liabilities, responsibilities, damages and claims which might result from release of information authorized above.

____________________________________  __________________________
Applicant Signature                      Date

____________________________________  __________________________
LIHEAP Program Representative          Date
FAIR HEARING STATEMENT

Client Appeal Rights:
If your application for assistance is denied or you feel your application was not handled in an efficient or timely manner, you may do the following:

- File a written appeal within ten (10) days of receiving a letter of denial to the CEO of K'ima:w Medical Center.
- The CEO of K'ima:w Medical Center will review your information and make a decision regarding your appeal within five (5) days of receiving your written appeal.
- If you are unhappy with K'ima:w Medical Center CEO's decision, final appellate authority rests with the K'ima:w Medical Center Board of Directors.

I have read and understand my appeal rights.

Applicant Signature ___________________________ Date ___________________________

RESPONSIBILITY STATEMENT

I, ____________________________________________, reside at ____________________________________________
(Print name) (Physical address)

My utility bill is in the name of: ____________________________, he/she is my _______________. I am responsible for payment of the utility bill for the address above.
(Relationship)

By signing this document, I certify that all information is true and correct to the best of my knowledge. I acknowledge that all information is subject to verification and I also understand that falsification of any information shall be grounds for termination K'ima:w Medical Center - An Entity of the Hoopa Valley Tribe's LIHEAP program.

Applicant Signature ___________________________ Date ___________________________