

K'ima:w Medical Center
An Entity of the Hoopa Valley Tribe
Low Income Home Energy Assistance Program (LIHEAP)
P.O. Box 1288 Hoopa, CA 95546
PH: 530-625-4261 FAX: 530-625-4858

LIHEAP 2023-2024 APPLICATION

Your application for Low Income Home Energy Assistance (LIHEAP) 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
[] 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 Application Form

2022-2023



Applicant Information

FIRST NAME	MIDDLE	LAST NAME	SUFFIX

ADDRESS (PO BOX)	CITY	STATE	ZIP CODE

PHYSICAL ADDRESS	CITY	STATE	ZIP CODE

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

HOOPA VALLEY TRIBAL MEMBER: YES NO ROLL#_____

(PLEASE ATTACH A COPY OF TRIBAL VERIFICATION)

ARE YOU DISABLED: YES NO

(PLEASE ATTACH PROOF OF DISABILITY)

Additional Household Members (list all residents of household)

Name	Relationship	Date of Birth	Age	Disabled

Energy Assistance Request

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

PG&E
Electricity

CAMPORA
Propane

AMERIGAS
Propane

JURY'S
Propane

VALLEY PACIFIC
Kerosene

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.)

Income Verification

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

Name of each person with income in the household:	TANF/CAL-WORKS	SSA	SSI	EMPLOYMENT	OTHER
EX: JANE DOE			\$900		

TOTAL HOUSEHOLD INCOME	\$
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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



K'ima:w Medical Center - An Entity of the Hoopa Valley Tribe
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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 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

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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.

	Energy Source:	Current Monthly Expense (if any):
1	WOOD	
2	PROPANE	
3	KEROSENE	
4	ELECTRICITY	

Office Use Only:

Total Monthly Expenses:	
Divide by Total Monthly Income	
Energy Burden %	

*** 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

K'ima:w Medical Center - An Entity of the Hoopa Valley Tribe
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~ 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

K'ima:w Medical Center - An Entity of the Hoopa Valley Tribe
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~ 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