



DEL NORTE LIHEAP UTILITY ASSISTANCE APPLICATION



Thank you for your interest in applying for help with your utility costs. In order for us to process your application, it is important that you provide everything listed below. All documentation must be current within six (6) weeks before your application.

Completed applications and backup documents may be mailed to or dropped off at the Del Norte Senior Center (DNSC), 1765 Northcrest Drive, Crescent City, CA 95531. For questions, call (707) 464-3069

TO APPLY FOR ASSISTANCE, YOU MUST PROVIDE ALL OF THE FOLLOWING

- Completed DNSC Application
- Completed Household Demographics for all Household Members
- Utility Responsibility Statement
- Income Verification Adults with no income must complete a Certification of Income and Expenses
 Examples: Paycheck stubs showing the past 30 days income
 Social Security/SSI award letters for the current year
 Verification of Benefits for CalWorks cash aid and/or CalFresh Food Stamps
 Retirement income statements showing monthly or annual payments
 Documentation of self-employment income or other income
- Government issued photo ID for adult household members
- Social Security Cards for all household members
- Most Recent Electric Utility Bill
- Most Recent Wood, Propane, Heating Oil or Other Heating Fuel Bills
- Pacific Power C.A.R.E. Application

Do Not Mail Originals. Mail copies or bring cards to DNSC to be copied.

STATE PROGRAM INFORMATION: AGENCY NAME: Community Services and Development (CSD). UNIT RESPONSIBLE FOR MAINTENANCE: Home Energy Assistance Program (HEAP). AUTHORITY: Government Code Section 16367.6 (a) Names CSD as the agency responsible for managing HEAP. PURPOSE: The information you provide will be used to decide if you are eligible for a LIHEAP payment and/or weatherization services. GIVING INFORMATION: This program is voluntary. If you choose to apply for assistance, you must give all required information. OTHER INFORMATION: CSD uses statistical definitions from the annual update of the Department of Health and Human Services' State Median Income, Federal Income Poverty Guidelines, to determine program eligibility. During application processing, CSD's designated subcontractor may need to ask you for more information to decide your eligibility for either or both programs. ACCESS: CSD's designated subcontractor will keep your completed application and other information, if used, to determine your eligibility. You have the right to access all records holding information about you. CSD does not discriminate in the provision of services on the basis of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, marital status, sex, age, or sexual orientation.



DEL NORTE LIHEAP
UTILITY ASSISTANCE APPLICATION



RETURN TO: 1765 NORTHCREST DRIVE, CRESCENT CITY, CA 95531

Applicant First Name		Middle Int.	Last Name																															
Applicant Social Security No.		Birth Date (MM/DD/YYYY)	Email																															
Landline Phone <input type="checkbox"/> Check if Message Only		Cellular/Mobile Phone	Do you agree to opt in to receive text messages? <input type="checkbox"/> Yes <input type="checkbox"/> No																															
Service/Street Address (Do not use P.O. Box) <input type="checkbox"/> Check if you've lived here all of the last 12 months.			Unit Number																															
Service City		Service County	Service State	Service ZIP Code																														
		Del Norte	CA																															
Mailing Address <input type="checkbox"/> Check if same as service/street address.				Unit Number																														
Mailing City		Mailing County	Mailing State	Mailing ZIP Code																														
		Del Norte	CA																															
HOUSEHOLD INFORMATION																																		
PEOPLE LIVING IN HOUSEHOLD Enter the number of people who are: <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td>2 years old or younger</td><td></td></tr> <tr><td>Ages 3 - 5 years</td><td></td></tr> <tr><td>Ages 6 - 18 years</td><td></td></tr> <tr><td>Ages 19 - 59</td><td></td></tr> <tr><td>Ages 60 or older</td><td></td></tr> <tr><td>TOTAL PEOPLE IN HH</td><td></td></tr> </table>		2 years old or younger		Ages 3 - 5 years		Ages 6 - 18 years		Ages 19 - 59		Ages 60 or older		TOTAL PEOPLE IN HH		INCOME How many people in the household receive income? <input style="width:50px; height:20px;" type="text"/> Enter total gross (pre-tax) monthly income for all people living in the household: <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td>TANF</td><td>\$</td></tr> <tr><td>SSI/SSP</td><td>\$</td></tr> <tr><td>SSA/SSDI</td><td>\$</td></tr> <tr><td>Paycheck(s)</td><td>\$</td></tr> <tr><td>Unemployment</td><td>\$</td></tr> <tr><td>Pension</td><td>\$</td></tr> <tr><td>Self-Employment</td><td>\$</td></tr> <tr><td>Other</td><td>\$</td></tr> <tr><td>TOTAL INCOME</td><td>\$</td></tr> </table>		TANF	\$	SSI/SSP	\$	SSA/SSDI	\$	Paycheck(s)	\$	Unemployment	\$	Pension	\$	Self-Employment	\$	Other	\$	TOTAL INCOME	\$	TYPE OF HOUSING <input type="checkbox"/> Single-Family Home/ House <input type="checkbox"/> Mobile Home <input type="checkbox"/> Duplex/Apartment complex with fewer than 4 units. <input type="checkbox"/> Apartment complex with more than 4 units. <input type="checkbox"/> Other
2 years old or younger																																		
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TANF	\$																																	
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Pension	\$																																	
Self-Employment	\$																																	
Other	\$																																	
TOTAL INCOME	\$																																	
HOUSEHOLD DEMOGRAPHICS Enter the number of people who are: <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td>Disabled</td><td></td></tr> <tr><td>Native American</td><td></td></tr> <tr><td>Limited-English Speaking</td><td></td></tr> <tr><td>Seasonal or Migrant Farmworker</td><td></td></tr> </table>		Disabled		Native American		Limited-English Speaking		Seasonal or Migrant Farmworker		HOUSING ARRANGEMENT <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Other																								
Disabled																																		
Native American																																		
Limited-English Speaking																																		
Seasonal or Migrant Farmworker																																		
Are you or someone in your household CURRENTLY receiving CalFresh (Food Stamps)? <input type="checkbox"/> YES <input type="checkbox"/> NO																																		
Are you or someone in your household CURRENTLY receiving CalWorks (Cash Aid)? <input type="checkbox"/> YES <input type="checkbox"/> NO																																		



DEL NORTE LIHEAP

UTILITY ASSISTANCE APPLICATION



DEMOGRAPHICS

Complete for all household members.

APPLICANT

First Name	MI	Last Name	Relationship to Applicant Self
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Date of Birth:	Gender:
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Race: <input type="checkbox"/> White/European <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other _____	Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Education Level: 0 to 8th Grade
 9th to 12th Grade
 HS Graduate/GED
 Some College
 College Degree

Does this person have Health Insurance? <input type="checkbox"/> No <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medicare <input type="checkbox"/> Other	Check all that apply: <input type="checkbox"/> Disabled <input type="checkbox"/> Migrant Farmworker <input type="checkbox"/> Farmer <input type="checkbox"/> Limited English Speaking <input type="checkbox"/> Seasonal Farmworker
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Have you served or are you an immediate family member of someone who served in the United States Military? No
 Yes, I served. Yes, I am the spouse, legal partner, parent or child of a person who served. Decline to state

I consent to this agency and CSD transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I or my family member may be eligible. I understand that this consent is valid for 12 months.

Yes No

HOUSEHOLD MEMBER 1

First Name	MI	Last Name	Relationship to Applicant
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Date of Birth:	Gender:
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Race: <input type="checkbox"/> White/European <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other _____	Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Education Level: 0 to 8th Grade
 9th to 12th Grade
 HS Graduate/GED
 Some College
 College Degree

Does this person have Health Insurance? <input type="checkbox"/> No <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medicare <input type="checkbox"/> Other	Check all that apply: <input type="checkbox"/> Disabled <input type="checkbox"/> Migrant Farmworker <input type="checkbox"/> Farmer <input type="checkbox"/> Limited English Speaking <input type="checkbox"/> Seasonal Farmworker
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HOUSEHOLD MEMBER 2

First Name	MI	Last Name	Relationship to Applicant
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Date of Birth:	Gender:
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Race: <input type="checkbox"/> White/European <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other _____	Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Education Level: 0 to 8th Grade
 9th to 12th Grade
 HS Graduate/GED
 Some College
 College Degree

Does this person have Health Insurance? <input type="checkbox"/> No <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medicare <input type="checkbox"/> Other	Check all that apply: <input type="checkbox"/> Disabled <input type="checkbox"/> Migrant Farmworker <input type="checkbox"/> Farmer <input type="checkbox"/> Limited English Speaking <input type="checkbox"/> Seasonal Farmworker
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DEL NORTE LIHEAP UTILITY ASSISTANCE APPLICATION



DEMOGRAPHICS, Continued

HOUSEHOLD MEMBER 3

First Name	MI	Last Name	Relationship to Applicant
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Date of Birth:	Gender:
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Race: <input type="checkbox"/> White/European <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other _____	Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Education Level: <input type="checkbox"/> 0 to 8th Grade <input type="checkbox"/> 9th to 12th Grade <input type="checkbox"/> HS Graduate/GED <input type="checkbox"/> Some College <input type="checkbox"/> College Degree

Does this person have Health Insurance? <input type="checkbox"/> No <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medicare <input type="checkbox"/> Other	Check all that apply: <input type="checkbox"/> Disabled <input type="checkbox"/> Migrant Farmworker <input type="checkbox"/> Farmer <input type="checkbox"/> Limited English Speaking <input type="checkbox"/> Seasonal Farmworker
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HOUSEHOLD MEMBER 4

First Name	MI	Last Name	Relationship to Applicant
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Date of Birth:	Gender:
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Race: <input type="checkbox"/> White/European <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other _____	Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Education Level: <input type="checkbox"/> 0 to 8th Grade <input type="checkbox"/> 9th to 12th Grade <input type="checkbox"/> HS Graduate/GED <input type="checkbox"/> Some College <input type="checkbox"/> College Degree

Does this person have Health Insurance? <input type="checkbox"/> No <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medicare <input type="checkbox"/> Other	Check all that apply: <input type="checkbox"/> Disabled <input type="checkbox"/> Migrant Farmworker <input type="checkbox"/> Farmer <input type="checkbox"/> Limited English Speaking <input type="checkbox"/> Seasonal Farmworker
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HOUSEHOLD MEMBER 5

First Name	MI	Last Name	Relationship to Applicant
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Date of Birth:	Gender:
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Race: <input type="checkbox"/> White/European <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other _____	Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Education Level: <input type="checkbox"/> 0 to 8th Grade <input type="checkbox"/> 9th to 12th Grade <input type="checkbox"/> HS Graduate/GED <input type="checkbox"/> Some College <input type="checkbox"/> College Degree

Does this person have Health Insurance? <input type="checkbox"/> No <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medicare <input type="checkbox"/> Other	Check all that apply: <input type="checkbox"/> Disabled <input type="checkbox"/> Migrant Farmworker <input type="checkbox"/> Farmer <input type="checkbox"/> Limited English Speaking <input type="checkbox"/> Seasonal Farmworker
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If there are more than 6 members in your household, please request additional pages.



DEL NORTE LIHEAP UTILITY ASSISTANCE APPLICATION



UTILITY ASSISTANCE

ELECTRIC UTILITIES - YOU MUST SUBMIT A COPY OF YOUR MOST RECENT BILL

All Electric? YES NO Pacific Power & Light Included in rent/submetered. Solar/Off-grid. None/Other

Account Number _____ Name of customer on utility bill: _____

Do you have a past due amount? YES NO Is your electricity shut off? YES NO

HOME HEATING FUEL - YOU MUST SUBMIT A COPY OF YOUR MOST RECENT BILL OR RECEIPT

What help are you requesting? (ONLY 1) <input type="checkbox"/> Electricity <input type="checkbox"/> Fuel Oil <input type="checkbox"/> Pellets <input type="checkbox"/> Propane <input type="checkbox"/> Wood <input type="checkbox"/> Kerosene <input type="checkbox"/> Manufactured Logs	Do you have any other heat source? <input type="checkbox"/> No <input type="checkbox"/> Fuel Oil <input type="checkbox"/> Propane <input type="checkbox"/> Pellets <input type="checkbox"/> Wood <input type="checkbox"/> Kerosene <input type="checkbox"/> Manufactured Logs <input type="checkbox"/> Space Heater	Are you currently out of fuel? <input type="checkbox"/> YES <input type="checkbox"/> NO How many days left? <input style="width: 50px; height: 20px;" type="text"/>
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If you use any non-electric home heating fuel, please complete the following:

Where do you usually buy home heating fuel?	Account Number	In one month, I use about:	Amount	Units

HOUSEHOLD USE ONLY: I understand and acknowledge that any help I receive is for the home heating use of my qualified household only. Any other use is fraud. I may be subject to arrest, prosecution and/or repayment of the full cost of services received if I sell, give away, trade or otherwise improperly use any of the home heating fuel that I receive.

CONSENT/ INFORMATION VERIFICATION: The information on this application will be used to determine and verify my eligibility for assistance. By signing below, I give my consent (permission) to CSD, its contractors, and consultants, other federal or state agencies (CSD Partners), and to my utility company(ies) and its contractors to share information about my household's utility account, energy usage and/or other information needed to provide services and benefits to me as described in these documents. My consent shall be effective for the period beginning 24 months prior to and continuing for 36 months after the date signed unless otherwise revoked by me in writing. I declare, under penalty of perjury, that the information on this application is true, correct, and that the funds received will be used solely for the purpose of paying my utility costs.

APPEAL: I understand that if my application for benefits or services is denied, or if I receive untimely response or unsatisfactory performance, I may initiate a written appeal with the local service provider and my appeal shall be reviewed no later than 15 days after the appeal is received. If I am not satisfied with the local service provider's decision I may then appeal to the Department of Community Services and Development pursuant to Title 22, California Code of Regulations section 100805.

Applicant's Signature _____ Date _____ Witness' Signature (if signed with an X) _____



DEL NORTE LIHEAP



CERTIFICATION OF INCOME AND EXPENSES

This form must be completed if a household is asking for assistance, and one or more adult household members doesn't have proof of income or states they have zero income. The State of California requires applicant households to report all sources of income.

All adult members of the household have provided proof of income. You do not need to complete this form.

One or more adult household members does not have any income. Please fill out the form below for each one.

Name and Address	
Name:	
Address:	

Section 1: Do you have sources of income you forgot to report? If yes, you must list the income on the application, page 1					
YES	NO	During the previous month have you been employed part time?			
YES	NO	During the previous month have you been self-employed?			
YES	NO	During the previous month did you receive money for any work that you perform only once in a while, like yard work, child care, donating blood, etc?			
YES	NO	During the previous month have you received any gifts of money from anyone? If yes, please list the name and phone number of the person who gave you the gift:			
YES	NO	During the previous month did you receive any of the following: (circle any that apply)			
		WORKER'S COMP	UNEMPLOYMENT	GOVERNMENT SPONSORED BENEFITS	CHILD SUPPORT
YES	NO	Do you receive any of the following (circle any that apply)			
		ANNUITY PAYMENT	PENSION	TRIBAL CASINO PAYMENTS	RENTAL INCOME
					INSURANCE BENEFITS

Section 2: Are you spending your savings or borrowing money to cover monthly expenses?		
YES	NO	Are you using savings or a home equity loan? How much? _____
YES	NO	Are you using some other asset? How much? _____
YES	NO	Are you borrowing from credit cards? How much? _____
YES	NO	Are you borrowing from some other source? How much? _____

Section 3: Please tell us how you paid these monthly expenses during the previous months:			
EXPENSE	MONTHLY COST	HOW HAS THE EXPENSE BEEN PAID?	IF SOMEONE ELSE PAYS FOR YOU, PLEASE COMPLETE:
Rent or Mortgage	\$		Name: _____ Address: _____ Phone: _____
Utility Bills	\$		Name: _____ Address: _____ Phone: _____
Food	\$		Name: _____ Address: _____ Phone: _____

Section 4: If none of the above applies to you, please explain how your monthly expenses were paid:

Signature:
By signing this form, I affirm that I believe these facts are accurate and true. I give the Service Provider my permission to verify this information. I may be held liable under federal or state law for knowingly making false or fraudulent statements.

Signature _____ Date _____



DEL NORTE LIHEAP UTILITY RESPONSIBILITY STATEMENT



APPLICANT LAST NAME

FIRST NAME

M.I.

SERVICE ADDRESS

CITY

ZIP

The **ELECTRIC bill** at the above address is:

- In my name.
- In someone else's name: _____ This person is my _____
 - I must pay the entire amount of the utility bill each month.
- Included in my rent or sub-metered by my landlord. Your landlord must sign this form.

The amount of my rent that covers utilities, or the amount that is sub-metered for this month is \$ _____

Signature of Landlord

Date

Address

Phone Number

Authorization and Consent of Utility Client of Record (if not the applicant)

By signing below, I acknowledge and authorize my utility company, the California Department of Community Services and Development and CSD Partners to release upon request and/or to receive information about my utility company billing records, account name, service address, billing history, account balances, historical and future usage and energy consumption data and information about weatherization of the dwelling exclusively for the purposes of processing utility bill assistance and emergency payments and to collect data on the impact of services on energy consumption and costs. This Authorization will remain in effect for up to 36 months unless revoked in writing.

Signature of Customer on Utility Bill

Date

- Check here if the customer on the utility bill is unreachable for signature.

I certify that all information is true and correct to the best of my knowledge. I am aware that willfully and knowingly falsifying information may lead to criminal prosecution. I am the only person in my household who has applied for Energy Assistance.

Applicant's Signature

Date

If you are a California resident, you have specific rights related to your personal information under the California Consumer Privacy Act. For more information, please request a copy of our privacy policy or find it on our website at www.PacificPower.net/Privacy.

CUSTOMER INFORMATION

Pacific Power Account No.

Name, as shown on your Pacific Power bill

Your home address (Address must be your primary residence. Do NOT use a P.O. Box)

City ZIP Code

Preferred phone number

Email address

Number of people in your household at this address + = Total combined annual household income ,

I am currently on a fixed income and receive income or benefits from one or more of the following: pensions, Social Security, SSP or SSDI, interest/dividends from retirement accounts, Medicaid/Medi-Cal (age 65 and over) or SSI. If so, please check (✓) this box.

PUBLIC ASSISTANCE PROGRAM ELIGIBILITY

- Please check (✓) this box if you or someone in your household participate in any of the following programs: Medi-Cal/Medicaid, CalFresh/SNAP (Food Stamps), CalWorks (TANF)/Tribal TANF, WIC, Medi-Cal for Families (Healthy Families A&B), LIHEAP, Supplemental Security Income (SSI), National School Lunch Program (NSL), Bureau of Indian Affairs General Assistance, Head Start Income Eligible (Tribal Only)

If you checked the Public Assistance Program Eligibility box above, SKIP to the DECLARATION section.

INCOME ELIGIBILITY

- Please check (✓) this box if you meet the income guideline qualifications. Applicants must add all sources of the households combined gross annual household income from ALL sources. Includes taxable and non-taxable income before deductions for all people who live in your home. Pensions, Social Security, SSP or SSDI, Interest or Dividends from Savings, Stocks, Bonds, or Retirement Accounts, Wages and/or Profits from Self-Employment, Unemployment Benefits, Disability or Workers' Compensation Payments, Rental or Royalty Income, Scholarships, Grants, or Other Aid Used for Living Expenses, Insurance or Legal Settlements, Spousal or Child Support, Cash and/or Other Income

DECLARATION (Please read carefully and sign below)

By signing this declaration, I state that the information I have provided in this application is true and correct. I also agree to follow the terms and conditions of the CARE program. I understand that Pacific Power reserves the right to verify my household eligibility and I agree to provide proof of eligibility, if asked. I understand that I may be required to participate in the Energy Savings Assistance Program and that unacceptable energy usage levels could result in removal from the program. I agree to inform Pacific Power if I no longer qualify to receive discount. I know that if I receive any discount without qualifying for it, I may be required to pay back discount received. I understand that Pacific Power can share my information with other utilities or agencies to enroll me in their assistance programs.

Pacific Power Customer Signature _____ Date _____

Check (✓) this box if someone in your household has a disability, or requires accessibility, financial or language support during a public safety power outage. Pacific Power will provide an additional notification prior to a public safety power shut off. For more information, visit PacificPower.net/Wildfire.

The California Alternate Rates for Energy (CARE) program provides a discount of 25% on monthly electric bills for eligible customers.

To qualify for CARE, customers must meet the following eligibility and income requirements:

- The Pacific Power bill must be in your name.
You must live at the address to which the discount applies
You may not be claimed as a dependent on another person's income tax return other than your spouse
You will need to renew your application every two years or when requested by Pacific Power

There are two ways to qualify for CARE:

- You can qualify if you or someone in your home participate in any of the eligible public assistance programs.
OR
You can also qualify if you meet the income guideline qualifications listed in the chart below.

CARE Income Guidelines table with columns: Household Size, Income Eligibility Upper Limit*. Rows include household sizes 1 to 2 through 8, and 'Each additional person'.

*Upper Limit Calculation = 200% of Federal Poverty Guidelines

For questions call toll-free: 1-888-221-7070

If you qualify, you can apply online at PacificPower.net/CARE or complete and mail the attached application to:

CARE Program Manager
Pacific Power
825 NE Multnomah, Suite 2000
Portland, OR 97232

