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	
☐ Disability Self Certification	
☐ 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	
Retirement income statements showing monthly or annual payments	
Documentation of self-employment income or other income	
☐ Government issued photo ID for adult household members	**Do Not Mail Originals.** Mail copies or bring cards to DNSC to be copied.
☐ 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	

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.

NOTE: An application is not a guarantee of benefits, even if you have received help in the past. You must continue to pay your utility bills until your application is processed and you receive a letter notifying you of the result.

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 ☐ Check if Message Only	Cellular/Mobile Phone	Do you agree to opt in to receive text messages? ☐ Yes ☐ No

Service/Street Address (Do not use P.O. Box) ☐ 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 ☐ 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:	
2 years old or younger	
Ages 3 - 5 years	
Ages 6 - 18 years	
Ages 19 - 59	
Ages 60 or older	
TOTAL PEOPLE IN HH	

HOUSEHOLD DEMOGRAPHICS	
Enter the number of people who are:	
Disabled	
Native American	
Limited-English Speaking	
Seasonal or Migrant Farmworker	

INCOME	
How many people in the household receive income?	
Enter total gross (pre-tax) monthly income for all people living in the household:	
TANF	$
SSI/SSP	$
SSA/SSDI	$
Paycheck(s)	$
Unemployment	$
Pension	$
Self-Employment	$
Other	$
TOTAL INCOME	$

TYPE OF HOUSING

- ☐ Single-Family Home/ House
- ☐ Mobile Home
- ☐ Duplex/Apartment complex with fewer than 4 units.
- ☐ Apartment complex with more than 4 units.
- ☐ Other

HOUSING ARRANGEMENT

- ☐ Own ☐ Rent
- ☐ Other

Are you or someone in your household CURRENTLY receiving CalFresh (Food Stamps)? ☐ YES ☐ NO

Are you or someone in your household CURRENTLY receiving CalWorks (Cash Aid)? ☐ YES ☐ NO

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*)
☐ Electricity ☐ Fuel Oil ☐ Pellets
☐ Propane ☐ Wood ☐ Kerosene
☐ Manufactured Logs

Do you have any other heat source?
☐ No ☐ Fuel Oil ☐ Propane
☐ Pellets ☐ Wood ☐ Kerosene
☐ Manufactured Logs ☐ Space Heater

Are you currently out of fuel?
☐ YES ☐ NO
How many days left? ____

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)* _____

DEMOGRAPHICS
Complete for all household members.

APPLICANT

First Name	MI	Last Name	Relationship to Applicant
			Self

Date of Birth: **Gender:**

Race: ☐ White/European ☐ Native American/Alaskan ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Multi-Racial ☐ Other _____

Hispanic/Latino? ☐ Yes ☐ No

Education Level: ☐ 0 to 8th Grade ☐ 9th to 12th Grade ☐ HS Graduate/GED ☐ Some College ☐ College Degree

Does this person have Health Insurance? ☐ No ☐ Medi-Cal ☐ Medicare ☐ Other

Check all that apply: ☐ Disabled ☐ Migrant Farmworker ☐ Farmer ☐ Limited English Speaking ☐ Seasonal Farmworker

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 informaiton 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

Date of Birth: **Gender:**

Race: ☐ White/European ☐ Native American/Alaskan ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Multi-Racial ☐ Other _____

Hispanic/Latino? ☐ Yes ☐ No

Education Level: ☐ 0 to 8th Grade ☐ 9th to 12th Grade ☐ HS Graduate/GED ☐ Some College ☐ College Degree

Does this person have Health Insurance? ☐ No ☐ Medi-Cal ☐ Medicare ☐ Other

Check all that apply: ☐ Disabled ☐ Migrant Farmworker ☐ Farmer ☐ Limited English Speaking ☐ Seasonal Farmworker

HOUSEHOLD MEMBER 2

First Name	MI	Last Name	Relationship to Applicant

Date of Birth: **Gender:**

Race: ☐ White/European ☐ Native American/Alaskan ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Multi-Racial ☐ Other _____

Hispanic/Latino? ☐ Yes ☐ No

Education Level: ☐ 0 to 8th Grade ☐ 9th to 12th Grade ☐ HS Graduate/GED ☐ Some College ☐ College Degree

Does this person have Health Insurance? ☐ No ☐ Medi-Cal ☐ Medicare ☐ Other

Check all that apply: ☐ Disabled ☐ Migrant Farmworker ☐ Farmer ☐ Limited English Speaking ☐ Seasonal Farmworker

DEMOGRAPHICS, Continued

HOUSEHOLD MEMBER 3

First Name	MI	Last Name	Relationship to Applicant

Date of Birth: **Gender:**

Race: ☐ White/European ☐ Native American/Alaskan ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Multi-Racial ☐ Other _____

Hispanic/Latino? ☐ Yes ☐ No

Education Level: ☐ 0 to 8th Grade ☐ 9th to 12th Grade ☐ HS Graduate/GED ☐ Some College ☐ College Degree

Does this person have Health Insurance? ☐ No ☐ Medi-Cal ☐ Medicare ☐ Other

Check all that apply: ☐ Disabled ☐ Migrant Farmworker ☐ Farmer ☐ Limited English Speaking ☐ Seasonal Farmworker

HOUSEHOLD MEMBER 4

First Name	MI	Last Name	Relationship to Applicant

Date of Birth: **Gender:**

Race: ☐ White/European ☐ Native American/Alaskan ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Multi-Racial ☐ Other _____

Hispanic/Latino? ☐ Yes ☐ No

Education Level: ☐ 0 to 8th Grade ☐ 9th to 12th Grade ☐ HS Graduate/GED ☐ Some College ☐ College Degree

Does this person have Health Insurance? ☐ No ☐ Medi-Cal ☐ Medicare ☐ Other

Check all that apply: ☐ Disabled ☐ Migrant Farmworker ☐ Farmer ☐ Limited English Speaking ☐ Seasonal Farmworker

HOUSEHOLD MEMBER 5

First Name	MI	Last Name	Relationship to Applicant

Date of Birth: **Gender:**

Race: ☐ White/European ☐ Native American/Alaskan ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Multi-Racial ☐ Other _____

Hispanic/Latino? ☐ Yes ☐ No

Education Level: ☐ 0 to 8th Grade ☐ 9th to 12th Grade ☐ HS Graduate/GED ☐ Some College ☐ College Degree

Does this person have Health Insurance? ☐ No ☐ Medi-Cal ☐ Medicare ☐ Other

Check all that apply: ☐ Disabled ☐ Migrant Farmworker ☐ Farmer ☐ Limited English Speaking ☐ Seasonal Farmworker

If there are more than 6 members in your household, please request additional pages.

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 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?
☐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: (check 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 what money you used to pay these monthly expenses during the previous months:

EXPENSE	MONTHLY COST	WHAT MONEY PAID THE EXPENSE?	IF SOMEONE ELSE PAYS FOR YOU, PLEASE COMPLETE:	
Rent or Mortgage	$		Name:	Phone:
			Address:	
Utility Bills	$		Name:	Phone:
			Address:	
Food	$		Name:	Phone:
			Address:	

Section 4: If none of the above applies to you, please explain where money came from to pay your monthly expenses:

_____

_____

_____

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

DEL NORTE LIHEAP
DISABILITY SELF-CERTIFICATION

APPLICANT LAST NAME _____ FIRST NAME _____ M.I. _____

SERVICE ADDRESS _____ CITY _____ ZIP _____

Certain LIHEAP services are impacted by the disability status of the household. Under California law, a "disabled person" is "any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment or is regarded as having such an impairment."

Major Life Activities "means functions necessary to be self-sufficient such as caring for oneself, walking, seeing, hearing, speaking, breathing, learning and working." (CCR Title 9, Section 10870.)

To confirm your household's disability status, please check one of the following:

☐ Our household does NOT have any members with a disability as defined above.

☐ Our household DOES have one or more members with a disability as defined above.

Please list all household members with a disability:

_____ _____

_____ _____

_____ _____

I declare that the foregoing is true and correct to the best of my knowledge. I understand that I may be asked to provide documentation that any household members listed above actually have a disability as defined in state law. I understand that making false statements to obtain services may be grounds for legal action.

_____ _____

Applicant's Signature Date

PACIFIC POWER CARE PROGRAM APPLICATION

Entire application must be completed and signed. PLEASE PRINT CLEARLY

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 ____ + ____ = ____
Adults Children Total

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 many 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	
Total gross annual household income Effective June 1, 2024 to May 31, 2025	
Household Size	Income Eligibility Upper Limit*
1 to 2	$42,300
3	$53,300
4	$64,300
5	$75,300
6	$86,300
7	$97,300
8	$108,300
Each additional person	$11,000

**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

PACIFIC POWER
POWERING YOUR GREATNESS

06/2025