



## Low Income Home Energy Assistance Program (LIHEAP)

### Checklist for Application for Assistance

This Checklist will aid you in submitting a complete application. If a question does not apply, enter "n/a" in the response section otherwise, complete all sections of the application.

- \_\_\_ Page 1 – Basic Household Information: Complete this page for the household.
- \_\_\_ Page 2 – Head of Household Information: Complete this page for the person applying for assistance.
- \_\_\_ Pages 3, 4, & 5 – Household Member Information: Complete these pages for each member of the Household, other than Head of Household. If only one person in the household, enter "n/a" in the "Family Member" name section for subsequent page(s). If more than 4 in the household, copy page 5 and complete for each additional member.
- \_\_\_ Page 6 – Housing and Utility Information: Complete this page as outlined. Once complete, sign the "Applicant Certification".
- \_\_\_ Supplemental Information: Complete this page in its entirety. If a section does not apply (i.e. you have reported income or the light bill is in your name), enter "n/a". Once complete, sign and date at the bottom of the page.
- \_\_\_ Notice Regarding Collection of Social Security Numbers: Read and sign at the bottom.
- \_\_\_ Authorization for Release of General and/or Confidential Information: Complete appropriate section and sign at the bottom.
- \_\_\_ Last Page – Section B: Complete if not the utility account holder. Otherwise, enter "n/a".

### **REQUIRED DOCUMENTS**

The below documents must be photocopied and included with your application.. **DO NOT INCLUDE** original as they cannot be returned.

- \_\_\_ Picture ID for all household members.
- \_\_\_ Copies of social security cards for all household members
- \_\_\_ Proof of income for the last 30 days for all household members receiving income.  
DO NOT Include Bank Statements.
- \_\_\_ Copy of your most recent light bill.
- \_\_\_ Copy of your most recent Food Stamp Letter (if applicable).
- \_\_\_ Copy of HUD/Section 8 50059 Form (if applicable)

Once complete, mail "Application for Assistance" and "Required Documents" in the same envelope to:

**The Agricultural and Labor Program, Inc.**

**PO Box 3126**

**Winter Haven, FL 33885-3126**



The Agricultural and Labor Program, Incorporated  
Community Services/Economic Development Division

Uniform Application for Service

Application Date: \_\_\_\_\_

Applicant Information	First Name: _____	Last Name: _____	MI: _____
	DOB: _____	SSN: _____	Referred by: _____
	Email (if available): _____	# of Household Members: _____	
	Phone # - Home: _____	Work: _____	Cell: _____

Household Information

<p><b>Household Type</b> (check only one)</p> <p><input type="checkbox"/> Single Person</p> <p><input type="checkbox"/> Single Parent/Female</p> <p><input type="checkbox"/> Single Parent/Male</p> <p><input type="checkbox"/> 2-Parent with Children</p> <p><input type="checkbox"/> 2 or more Adults- no Children</p> <p><input type="checkbox"/> Multi-generational</p> <p><input type="checkbox"/> Non-Related Adults</p> <p><input type="checkbox"/> Other (Describe): _____</p>	<p><b>Housing Type:</b> (check only one)</p> <p><input type="checkbox"/> Rent</p> <p><input type="checkbox"/> Own</p> <p><input type="checkbox"/> Homeless</p> <p><input type="checkbox"/> Rooming House or Boarder</p> <p><input type="checkbox"/> Section 8</p> <p><input type="checkbox"/> Other (Describe): _____</p>	<p><b>Characteristics:</b> (check only one)</p> <p><input type="checkbox"/> Seasonal Farmworker</p> <p><input type="checkbox"/> Migrant Farmworker</p> <p><input type="checkbox"/> Farmer</p> <p><input type="checkbox"/> None of the above</p>	<p><b>Sources of Household Income</b> (check only one)</p> <p><input type="checkbox"/> Employment Only</p> <p><input type="checkbox"/> Employment &amp; Other Cash (ie: Retirement)</p> <p><input type="checkbox"/> Employment &amp; Non-Cash (ie: SNAP)</p> <p><input type="checkbox"/> Employment; Other Cash; and Non-Cash</p> <p><input type="checkbox"/> Other Cash (ie: SS, SSI, family support)</p> <p><input type="checkbox"/> Other &amp; Non-Cash</p>
<p><b>Other Income Sources</b> (check all that apply)</p> <p><input type="checkbox"/> Alimony/Spousal Support    <input type="checkbox"/> Child Support</p> <p><input type="checkbox"/> Social Security (SS)        <input type="checkbox"/> Retirement Pension</p> <p><input type="checkbox"/> S.S. Disability (SSDI)       <input type="checkbox"/> SSI</p> <p><input type="checkbox"/> Unemployment                <input type="checkbox"/> Worker's Comp.</p> <p><input type="checkbox"/> TANF                              <input type="checkbox"/> Earned Income Tax Credit</p> <p><input type="checkbox"/> VA Non-Service Rel.        <input type="checkbox"/> VA Service Related</p> <p><input type="checkbox"/> Other (Describe): _____</p>	<p><b>Non-Cash Benefits</b> (check all that apply)</p> <p><input type="checkbox"/> SNAP/Food Stamps</p> <p><input type="checkbox"/> WIC</p> <p><input type="checkbox"/> Housing Choice Voucher</p> <p><input type="checkbox"/> Childcare Voucher</p> <p><input type="checkbox"/> Affordable Care Subsidy</p> <p><input type="checkbox"/> Public Housing</p> <p><input type="checkbox"/> Supportive Housing</p> <p><input type="checkbox"/> HUD-VASH (veterans)</p> <p><input type="checkbox"/> Other (Describe): _____</p>	<p><b>Household Includes</b> (check all that apply)</p> <p><input type="checkbox"/> At least one member 60+</p> <p><input type="checkbox"/> At least one member disabled</p> <p><input type="checkbox"/> At least one child 5 years or younger</p>	<p><b>If Home Owner</b></p> <p>Year Home Built: _____</p> <p>Weatherization Received? _____</p> <p>If so what year? _____</p>

**Addresses**  
(If home and mailing addresses are different, complete both sections below)

<p><b>Home Address:</b></p> <p>Address: _____</p> <p>Suite/Apartment # (if applicable): _____</p> <p>City: _____ State: FL Zip: _____</p> <p>County: _____</p>	<p><b>Mailing Address:</b></p> <p>Address: _____</p> <p>Suite/Apartment # (if applicable): _____</p> <p>City: _____ State: FL Zip: _____</p> <p>County: _____</p>
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The Agricultural and Labor Program, Incorporated  
 Community Services/Economic Development Division  
 Uniform Application for Service (continued)

Applicant (First and Last Name): \_\_\_\_\_

Applicant (Head of Household) Information

**Race:**  
(Check only one)

Black/African American     White  
 Hispanic     Asian  
 Multi-Race     American Indian/  
 Native Hawaiian/     Alaskan Native  
 Pacific Islander     Other (Describe): \_\_\_\_\_  
 Not Reported

**Ethnicity:**  
(Check only one)

I am Hispanic  
 I am Not  
 Hispanic

**Gender:**  
(check only one)

Male  
 Female

**Relationship to Applicant:**  
 \_\_\_\_\_  
 Self  
 (i.e. Applicant, Spouse, son, daughter, uncle, etc.)

DOB: See first page

Age: \_\_\_\_\_

**Education:**  
(check only one)

Grades 0-8     2 or 4 years College Grad  
 Grades 9-12     Grad or Other Post-Secondary  
 HS Grad or GED     Other (Describe): \_\_\_\_\_  
 12<sup>th</sup> Grade and Some  
 Post Secondary

**Special Status:**  
(check all that applies)

I am between 18-24 years  
 of age and Not Working  
 I am disabled

**Source(s) of Income:**  
(i.e. Wages, SSN, Retirement, etc.)

First Source of Income: \_\_\_\_\_ Amount per month: \_\_\_\_\_  
 Second Source of Income: \_\_\_\_\_ Amount per month: \_\_\_\_\_

**Health Insurance:**  
(check if applies)

I have Health Insurance

Type of insurance

Medicare     Medicaid  
 Employer     Direct  
 Provided     Purchase  
 Children's Health (CHIP)  
 State provided Adult Health  
 Other (Describe): \_\_\_\_\_

**Work Status:**  
(check only one)

I work full-time     I work part-time  
 I am retired  
 I have been unemployed     I have been unemployed  
 60 days or less    more than 60 days.

**Military Status:**  
(check only one)

I am a veteran     I am currently on active  
 duty  
 I am currently in     I have never been in  
 the military reserve    the military

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



The Agricultural and Labor Program, Incorporated  
Community Services/Economic Development Division  
Uniform Application for Service (continued)

Family Member First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_  
SSN: \_\_\_\_\_ Email (if available): \_\_\_\_\_ Phone # (if available): \_\_\_\_\_

**Race:**  
(Check only one)

Black/African American     White  
 Hispanic     Asian  
 Multi-Race     American Indian/  
Native Hawaiian/    Alaskan Native  
Pacific Islander     Other (Describe): \_\_\_\_\_  
 Not Reported

**Ethnicity:**  
(Check only one)

I am Hispanic  
 I am Not  
Hispanic

**Gender:**  
(check only one)

Male  
 Female

**Relationship to Applicant:**  
\_\_\_\_\_  
(i.e. Applicant, Spouse, son, daughter, uncle, etc.)

DOB: \_\_\_\_\_

Age: \_\_\_\_\_

**Education:**  
(check only one)

Grades 0-8     2 or 4 years College Grad  
 Grades 9-12     Grad or Other Post-Secondary  
 HS Grad or GED     Other (Describe): \_\_\_\_\_  
 12<sup>th</sup> Grade and Some  
Post Secondary

**Special Status:**  
(check all that applies)

I am between 18-24 years  
of age and Not Working  
 I am disabled

**Source(s) of Income:**  
(i.e. Wages, SSN, Retirement, etc.)

First Source of Income: \_\_\_\_\_ Amount per month: \_\_\_\_\_  
Second Source of Income: \_\_\_\_\_ Amount per month: \_\_\_\_\_

**Health Insurance:**  
(check if applies)

I have Health Insurance

Type of insurance

Medicare     Medicaid  
 Employer     Direct  
Provided    Purchase  
 Children's Health (CHIP)  
 State provided Adult Health  
 Other (Describe): \_\_\_\_\_

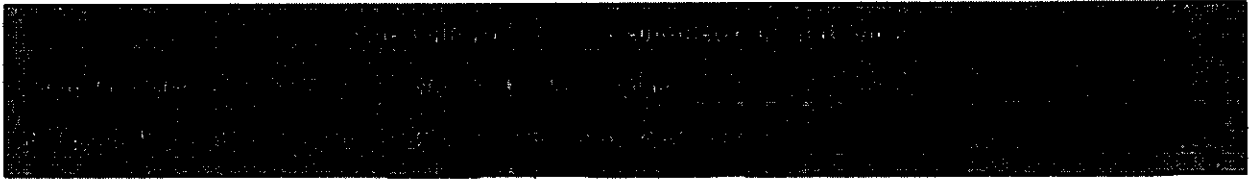
**Work Status:**  
(check only one)

I work full-time     I work part-time  
 I am retired  
 I have been unemployed     I have been unemployed  
60 days or less    more than 60 days.

**Military Status:**  
(check only one)

I am a veteran     I am currently on active  
duty  
 I am currently in     I have never been in  
the military reserve    the military

Family Member Information





The Agricultural and Labor Program, Incorporated  
 Community Services/Economic Development Division  
 Uniform Application for Service (continued)

Family Member First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_  
 SSN: \_\_\_\_\_ Email (if available): \_\_\_\_\_ Phone # (if available): \_\_\_\_\_

Family Member Information

**Race:**  
 (Check only one)

Black/African American     White  
 Hispanic     Asian  
 Multi-Race     American Indian/  
 Native Hawaiian/    Alaskan Native  
 Pacific Islander     Other (Describe): \_\_\_\_\_  
 Not Reported

**Ethnicity:**  
 (Check only one)

I am Hispanic  
 I am Not  
 Hispanic

**Gender:**  
 (check only one)

Male  
 Female

**Relationship to Applicant:**  
 \_\_\_\_\_  
 (i.e. Applicant, Spouse, son, daughter, uncle, etc.)

DOB: \_\_\_\_\_

Age: \_\_\_\_\_

**Education:**  
 (check only one)

Grades 0-8     2 or 4 years College Grad  
 Grades 9-12     Grad or Other Post-Secondary  
 HS Grad or GED     Other (Describe): \_\_\_\_\_  
 12<sup>th</sup> Grade and Some  
 Post Secondary

**Special Status:**  
 (check all that applies)

I am between 18-24 years  
 of age and Not Working  
 I am disabled

**Source(s) of Income:**  
 (i.e. Wages, SSN, Retirement, etc.)

First Source of Income: \_\_\_\_\_ Amount per month: \_\_\_\_\_  
 Second Source of Income: \_\_\_\_\_ Amount per month: \_\_\_\_\_

**Health Insurance:**  
 (check if applies)

I have Health Insurance

Type of insurance

Medicare     Medicaid  
 Employer     Direct  
 Provided    Purchase  
 Children's Health (CHIP)  
 State provided Adult Health  
 Other (Describe): \_\_\_\_\_

**Work Status:**  
 (check only one)

I work full-time     I work part-time  
 I am retired  
 I have been unemployed     I have been unemployed  
 60 days or less    more than 60 days.

**Military Status:**  
 (check only one)

I am a veteran     I am currently on active  
 duty  
 I am currently in     I have never been in  
 the military reserve    the military

Signature: \_\_\_\_\_  
 Date: \_\_\_\_\_



The Agricultural and Labor Program, Incorporated  
 Community Services/Economic Development Division  
 Uniform Application for Service (continued)

Family Member: First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 SSN: \_\_\_\_\_ Email (if available): \_\_\_\_\_ Phone # (if available): \_\_\_\_\_

Family Member Information

**Race:**  
(Check only one)

Black/African American     White  
 Hispanic     Asian  
 Multi-Race     American Indian/  
 Native Hawaiian/     Alaskan Native  
 Pacific Islander     Other (Describe): \_\_\_\_\_  
 Not Reported

**Ethnicity:**  
(Check only one)

I am Hispanic  
 I am Not  
 Hispanic

**Gender:**  
(check only one)

Male  
 Female

**Relationship to Applicant:**  
 \_\_\_\_\_  
 (i.e. Applicant, Spouse, son, daughter, uncle, etc.)

**DOB:** \_\_\_\_\_

**Age:** \_\_\_\_\_

**Education:**  
(check only one)

Grades 0-8     2 or 4 years College Grad  
 Grades 9-12     Grad or Other Post-Secondary  
 HS Grad or GED     Other (Describe): \_\_\_\_\_  
 12<sup>th</sup> Grade and Some  
 Post Secondary

**Special Status:**  
(check all that applies)

I am between 18-24 years  
 of age and Not Working  
 I am disabled

**Source(s) of Income:**  
(i.e. Wages, SSN, Retirement, etc.)

**First Source of Income:** \_\_\_\_\_ **Amount per month:** \_\_\_\_\_  
**Second Source of Income:** \_\_\_\_\_ **Amount per month:** \_\_\_\_\_

**Health Insurance:**  
(check if applies)

I have Health Insurance

Type of insurance

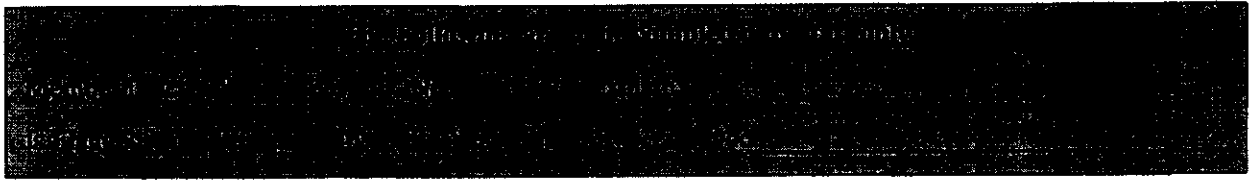
Medicare     Medicaid  
 Employer     Direct  
 Provided     Purchase  
 Children's Health (CHIP)  
 State provided Adult Health  
 Other (Describe): \_\_\_\_\_

**Work Status:**  
(check only one)

I work full-time     I work part-time  
 I am retired  
 I have been unemployed     I have been unemployed  
 60 days or less    more than 60 days.

**Military Status:**  
(check only one)

I am a veteran     I am currently on active  
 duty  
 I am currently in     I have never been in  
 the military reserve    the military





The Agricultural and Labor Program, Incorporated  
 Community Services/Economic Development Division  
 Uniform Application for Service (continued)

**Housing Information (if available)**

<b>Rental Information:</b> Monthly Rent: _____ <input type="checkbox"/> Utilities Included <input type="checkbox"/> Subsidized (ie: Sect. 8) <b>Rented House Type:</b> <input type="checkbox"/> Apartment <input type="checkbox"/> Mobile Home <input type="checkbox"/> Private Home <input type="checkbox"/> Room/Boarding House	<b>Landlord (if known):</b> Landlord Name: _____ Address: _____ _____ City: _____ State: _____ Zip: _____ County (if known): _____ Phone #: _____	<b>Homeowner Information (if applicable):</b> Occupied by: <input type="checkbox"/> Single Family <input type="checkbox"/> Multi Family Monthly Payment: _____ House Type: <input type="checkbox"/> Single Family <input type="checkbox"/> Multi-Family <input type="checkbox"/> Condominium/ Townhouse
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**Utility Information (if available)**

Electric Co.: \_\_\_\_\_ Acct. #: \_\_\_\_\_ Heat  Cool  Both  None  
 Name on Account: \_\_\_\_\_

Gas Co.: \_\_\_\_\_ Acct. #: \_\_\_\_\_ Heat  Cool  Both  None  
 Name on Account: \_\_\_\_\_

Propane Co.: \_\_\_\_\_ Acct. #: \_\_\_\_\_ Heat  Cool  Both  None  
 Name on Account: \_\_\_\_\_

Water Co.: \_\_\_\_\_ Acct. #: \_\_\_\_\_  
 Name on Account: \_\_\_\_\_

Others #1: \_\_\_\_\_ Acct. #: \_\_\_\_\_ Type: \_\_\_\_\_

Type of Air Conditioning:  Central  Window Unit  Portable  Dehumidifier  NONE

Type of Heating:  Central  Space Heater  Fireplace  Stove  Wall Furnace  NONE

Primary Heating Annual Cost (if known): \_\_\_\_\_ Primary Heating Fuel Source: \_\_\_\_\_

Annual Electric (if known): \_\_\_\_\_ Annual Electric Cost Source: \_\_\_\_\_

**Applicant Certification**

I hereby certify that I participated in completion of the above "Uniform Application for Service". I further certify that I have read, or had read to me, the above information and, to the best of my knowledge and belief, the information is accurate and has been properly recorded. Additionally, I understand that I am responsible for the accuracy of the information provided and that said information will be used as a basis for determining my eligibility for services. I also understand that any falsification or misrepresentation of this information is just cause for denial of services and prosecution for fraud.

Applicant's signature: \_\_\_\_\_

Staff Signature: \_\_\_\_\_

Staff Printed Name: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_

Supervisor's Printed Name: \_\_\_\_\_

## SUPPLEMENTAL INFORMATION

1. Explain, how do you maintain yourself if you don't have NO INCOME or if your income is lower than \$500 a month?

2. Explain the reason why your light bill is not under your name?

3. Please identify the relationship you have with the person on the light bill? *Example: mother, landlord, etc.*

4. If you have members of your family that are over 18 years of age and are not working, studying or receiving any benefits. Please Explain why?

	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

➡ Applicant's Signature \_\_\_\_\_

Date \_\_\_\_\_



## NOTICE REGARDING COLLECTION OF SOCIAL SECURITY NUMBERS

### LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

The following disclosure is being made pursuant to section 119.071(5), Florida Statutes.

Social security numbers of applicants and household members are requested because this information has been determined to be imperative for the performance of the duties and responsibilities prescribed by law under the Low Income Home Energy Assistance Program. This information is not required by state or federal law; however, social security numbers are necessary to determine eligibility for program services and specifically for the following purposes:

1. To verify an applicant's identity.
2. To verify household size.
3. To verify household income.

A social security number collected pursuant to this notice can only be used by the Florida Department of Economic Opportunity and The Agricultural and Labor Program, Inc. (subgrantee) for the purposes specified above.

#### **Nondisclosure except under limited circumstances**

Social security numbers will not be disclosed to others unless required or authorized by Florida law. Section 119.071(5), Florida Statutes, allows disclosure of a person's social security number under the following specific, limited circumstances:

- If disclosure is expressly required by federal or Florida law or is necessary for the agency or governmental entity to perform its duties and responsibilities;
- If the individual expressly consents to disclosure in writing;
- If disclosure is made to prevent and combat terrorism pursuant to the U.S. Patriot Act of 2001 or Presidential Executive Order 13224 (blocking property and prohibiting business transactions with persons who commit, threaten to commit, or support terrorism);
- For an agency employee and dependents, if disclosure is necessary to administer the person's health benefits or pension plan funds; or
- If disclosure is for the purpose of the administration of the Uniform Commercial Code by the office of the Secretary of State.
- If disclosure is requested by a commercial entity for permissible uses under the federal Driver's Privacy Protection Act of 1994, the federal Fair Credit Reporting Act, or the federal Financial Services Modernization Act of 1999 (for example, to verify the accuracy of personal information provided by the individual to the commercial entity; use by an insurer in connection with claims investigation or anti-fraud activities; for use in connection with a credit transaction).

#### **Acknowledgment of Receipt of Notice**

I confirm that I have been provided a copy of this Notice regarding the collection of my social security number and the social security numbers of all household occupants as part of the application process for the Florida Low Income Home Energy Assistance Program.



\_\_\_\_\_

Applicant's Signature

\_\_\_\_\_

Agency Staff Signature



**Authorization for Release of General and/or Confidential Information  
For LIHEAP/EHEAP Federal Reporting**

The Florida Department of Economic Opportunity's (DEO) Low Income Home Energy Assistance Program (LIHEAP) Program Office is requesting that you authorize your utility service provider to disclose the following information to the LIHEAP office to which you are applying for assistance:

- Your utility account status and history, such as payment history, past due amounts, deposits, current shut-off due dates or disconnection, current life support status, payment arrangements, and history of energy assistance payments.
- Your total annual energy usage and charges for up to twelve months.

The Florida LIHEAP office and its contractors will use this information to develop LIHEAP program performance measures and meet Federal reporting requirements.

Please note that:

- You have a right to receive a copy of this form.
- You are not required to authorize your utility service provider to disclose your customer data.
- Your decision not to authorize the disclosure will not affect your utility services or any LIHEAP assistance you may be eligible for.
- Your utility service provider may not disclose your customer data unless you authorize the disclosure to the LIHEAP office, DEO, or as otherwise permitted or required by laws or regulations.
- Your utility service provider will have no control over the data disclosed pursuant to this consent, and will not be responsible for monitoring or taking any steps to ensure that the Florida LIHEAP office maintains the confidentiality of the data or uses the data as authorized by you.
- The Florida LIHEAP office will not disclose any private applicant information except for the purpose of administering public assistance as defined by State and Federal laws and regulations and developing LIHEAP program performance measures.

<b>ACCOUNT HOLDER (CUSTOMER NAME):</b>	
<b>SERVICE ADDRESS FOR UTILITY:</b>	
<b>NAME OF UTILITY SERVICE PROVIDER:</b>	
<b>UTILITY ACCOUNT NUMBER:</b>	
<b>PHONE NUMBER FOR UTILITY ACCOUNT:</b>	

**SECTION A: APPLICANT READS AND COMPLETES THIS SECTION ONLY IF HE/SHE IS THE ACCOUNT HOLDER**

I hereby authorize the above named utility and this agency to disclose pertinent information regarding my account to agencies that may provide me financial assistance, including the Florida LIHEAP Office. I understand that the purpose of this disclosure is solely for federal reporting purposes and does not determine my eligibility for assistance. I further understand that some of the information the above named utility may provide to this agency may be considered confidential. I also understand that the above named utility does not and will not have control over any account information provided to agencies pursuant to this Authorization, and I will hold the utility harmless for any claim related to the account information provided. All information is accurate to the best of my knowledge. The agency may verify information contained in the payment assistance application, including the utility account for which I am seeking assistance.

⇒ **ACCOUNT HOLDER'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SECTION B: APPLICANT READS AND COMPLETES THIS SECTION ONLY IF HE/SHE IS NOT THE ACCOUNT HOLDER**

As applicant for payment assistance for the above named utility account, I hereby confirm, under penalty of perjury, that I am an Authorized Representative on behalf of the Account Holder and I have authority to initiate this assistance application on his/her behalf. This may be confirmed at the agency's discretion, by contacting the Account Holder. I, and the Account Holder, understand that the purpose of this disclosure is solely for federal reporting purposes and does not determine my eligibility. I further understand that some of the information the above named utility may provide to this agency may be considered confidential. I also understand that the above named utility does not and will not have control over any account information provided to agencies pursuant to this Authorization, and I will hold the utility harmless for any claim related to the account information provided. All information is accurate to the best of my knowledge. The agency may verify information contained in the payment assistance application, including the utility account for which I am seeking assistance.

APPLICANT'S NAME (NOT ACCOUNT HOLDER): \_\_\_\_\_

APPLICANT'S PHONE NUMBER: \_\_\_\_\_

⇒ APPLICANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**SECTION C: FOR AGENCY USE ONLY**

Agency must maintain this form in the Applicant's file and make it available to the utility vendor of record upon request, for accounting and auditing purposes.

AGENCY NAME: THE AGRICULTURAL AND LABOR PROGRAM, INC.

PHONE: 863-956-3491

AGENCY CASEWORKER'S NAME: \_\_\_\_\_

AGENCY CASEWORKER'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_