



The Arc Utility Support Program Application

- _____ 1st Step Referral
- _____ Provider Referral
- _____ Direct Contact with The Arc
- _____ Other _____

Name of Applicant _____

Address _____ City _____

Phone 1 _____ Phone 2 _____ Email _____

of persons in household _____ # in household with disabilities _____

Name(s) of person with disabilities _____

of children under age 18 _____ Name(s) of children under 18 _____

Relationship of child(ren) with Applicant: Son _____ Daughter _____

If other relative explain _____

Family/Household Income: List all of the family/household members who support the family/have a source of income.

Please indicate the amount and frequency of pay for each person	1	2	3	Monthly total
Name of person receiving income				
TANF				
Wages/fees/commissions/tips/sick benefits				
Social Security / SSI				
Dividends / Interest on Savings				
Unemployment Compensation / Strike Benefits				
Alimony / Child Support				
Any other payments/ support/ Income				
Regular contributions from persons not living in the household				
Hours worked per week				
Is this month's income the same as the previous three months			Yes	No

List Employer Information for wage income in grid:

Name of employer 1 _____

Name of employer 2 _____

Name of employer 3 _____

Are you or a family member receiving Medicaid? _____ Waiver Services? _____

Does the person with disabilities receive services? _____

If yes, list provider _____

Provide any additional information about the household income: _____

Utility Assistance Information

Living Situation: Own _____ Rent _____ Subsidized Housing _____ Other _____

Type: Framed House _____ Duplex/Townhouse _____ Mobile Home _____ Apartment _____

Other _____

Utility/Heating-Cooling Payment: Included in Rent _____ Pay(Monthly) Bill _____

Other _____

Method of Heating: Electric _____ Natural Gas _____ Propane _____ Fuel Oil _____

Other _____

Utility Provider(s)

Name of Primary Heating Source/Utility _____ Acct # _____

Address _____ Name on Account _____

Electric Company Name _____ Acct # _____

Address _____ Name on Account _____

*If name is different than applicant explain: _____

Type of Assistance Requesting/Needed

Do you have a Disconnect Notice? Yes _____ No _____ Is your heat / electric shut off _____

Do you have a past bill that prevents you from receiving heat/electricity? Yes _____ No _____
What is the date of the bill/when was it due? _____

Do you need assistance with a deposit payment to begin service? Yes _____ No _____

Amount needed? _____

What is the monthly/estimated utility bill? Electric \$ _____ Gas \$ _____

Other \$ _____

If bulk fuel (oil/propane) what percentage is your tank at? _____%

Other Information

****Please include a copy of your bill or disconnection notice with this submittal****

Certification of Information Provided

By signing below, I certify that all information provided is correct and true. My signature also certifies that The Arc's Utility Support Program, and its agents and the agency that is assisting me with this application, has my permission for confidential information to be shared with all vendors, utility suppliers, landlords and/or all relevant agencies in order to complete the application for The Arc's Utility Support Program.

I understand that if I am denied or determined ineligible for benefits and I do not agree with the reasons stated, or if my application is not processed in a timely manner may appeal in writing. I understand that I should not assume that I am eligible for assistance and am legally responsible for all utility bills and expenses.

I further understand if I am determined eligible for assistance, any assistance shall be made directly to utilities companies/vendors and not to me or my family.

Applicant Signature _____ Date _____

Intake/Provider Assistance and Verification

Individual/agency staff that assisted the applicant with the application must sign the application, verifying that then information provided is believed to be true and accurate. Additionally the agency staff should identify and verify known program eligibility factors.

Agency Staff Signature

Intake/Agency Site-Name

Date

Check all information that is known/been verified/contained in agency or other records

_____ Person w/ Disability in household

_____ Person w/Disability/Family receives Medicaid

_____ Household receives TANF

_____ Child in household receives 1st Steps Svcs

_____ Household has child under age 18

_____ Person w/Disability receives Medicaid Waiver Services

_____ Household receives SSI

_____ Child in household receives Special Education services

Point of Contact-Utility Support Program Coordinator

Ms. Gina DeWilde

Phone: 800-573-9816

Email: gdewilde@arcind.org

Fax: 800-573-9816

Please return application to:



107 N. Pennsylvania Street, Suite 800

Indianapolis, IN 46204