The Arc Utility Support Program Application

The Arc Indiana

_____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 under18_____

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 receives1st 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:

The Arc Indiana

107 N. Pennsylvania Street, Suite 800

Indianapolis, IN 46204