Application for Assistance LIHEAP

Main Office
PO Box 1027
Klamath, CA 95548
Phone (707) 482-1350
Fax (707) 482-1368
Toll Free 1-800-242-0684

Humboldt Office
525 7th Street
Eureka, CA 95501
Phone (707) 445-2422
Fax (707) 445-2428

CHECKLIST

Be sure to complete all of the necessary information in order for your application to be processed. Your application will remain active for ten (10) days in order to give you the opportunity to collect the documentation needed. After ten (10) days, the application will be inactive

☐ Completed Application

☐ Tribal Verification

☐ All Household Names and Information (Including Social Security #’s)

☐ Income Verification for all Household Members :

(including Most Recent Paystubs, Passport to Services, Tribal TANF stubs, Award Letter or Direct Deposit statement for Social Security &/or Retirement, Disability Stubs or Statements and Unemployment Stubs)

☐ Verification of Need * (Copy of power bill & etc., read below)

☐ Proof of Handicap or Disability (If requesting LIHEAP)

*All services requested require appropriate documentation from vendors. Please make sure you attach a copy of your MOST RECENT Power Bill, invoice for Propane, Kerosene/Diesel for Monitor Heaters, and Pellets.

Payments will be made directly to vendor.

Adopted: 9/06
Revised: 09/14
Application For Assistance

Client Name:_________________________ Tribal ID #: ___________ DOB:__________

Mailing Address:________________________ City:_______________ Zip:__________

Telephone:____________________________ S.S.#________________

District:  South___ East___ North___ Orick___ Requa___ Pecwan___ Weitchpec___

LIST ALL HOUSEHOLD MEMBERS (other than self)

<table>
<thead>
<tr>
<th>NAME</th>
<th>DOB</th>
<th>Age</th>
<th>Tribal Roll #</th>
<th>SS#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MONTHLY INCOME FOR ALL HOUSEHOLD MEMBERS

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>NAME</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TANF/CalWorks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Security/SSI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veteran’s Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Describe your situation:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Certification: By signing this document I am certifying that all information provided, oral and written are true. I acknowledge that such information is subject to verification and that falsification of this information shall be grounds for denial and/or reimbursement of funds received from this program. I am the only person in my household who had applied for this program.

Applicant Signature:_________________________________________ Date:___________________

Adopted: 9/06
Revised: 09/14
AUTHORIZATION TO RELEASE INFORMATION

PO Box 1027
Klamath, CA 95548
Phone (707) 482-1350
Fax (707) 482-1368

525 7th Street
Eureka, CA 95501
Phone (707) 445-2422
Fax (707) 445-2428

I, ________________________, hereby authorize Yurok Social Services, a department of the Yurok Tribe, and the organizations and/or individuals indicated below by my initials to release and receive information concerning my case and/or the case of my dependent(s) named below. I have been informed of the type of information to be requested and released.

Initial all that apply:

_____ Department of Health and/or Social Services of ________________ County.

_____ United Indian Health Service and/or the following clinics and health programs:

______________________________________________________________________________

_____ Probation Department of ________________ County.

_____ My dependents who are covered by this release are: ____________________________

______________________________________________________________________________

_____ Juvenile and/or Dependency Court of ________________ County

_____ The following school(s) ____________________________

_____ Other ____________________________

_____ I hereby release the Yurok Tribe and its agents and employees from any/all liabilities, responsibilities, damages and claims which might result from release of information authorized above.

_____ I understand that the above consent is subject to revocation by me at any time, except to the extent that action has been taken in reliance on this consent prior to revocation.

SS# ___________________________________  DOB ___________________________________

Applicant Signature ___________________________  Date ____________________________

This release will be in effect for one year from the date it was signed unless terminated earlier at the request of the client.

Adopted: 9/06
Revised: 09/14
YUROK SOCIAL SERVICES

Verification of Unemployment/No Income

Main Office
PO Box 1027
Klamath, CA 95548
Phone (707) 482-1350
Fax (707) 482-1368

Humboldt County Office
525 7th Street
Eureka, CA 95501
Phone (707) 445-2422
Fax (707) 445-2428

Fill out for each person in household 18 years or older without employment or any income

I__________________________________________am currently unemployed and/or not
(Print Name)
receiving any benefits or income.

Last employer: _______________________________ Date last worked: _______________

Reason no longer working: _______________________________________________________
____________________________________________________

I certify that all information is true and correct to the best of my knowledge. I am also aware
that Yurok Tribe Social Services may verify my status with the Employment Development
Department or other necessary agencies. I acknowledge that such information is subject to
verification and that falsifying of this information shall be grounds for denial and reimbursement
of any and all funds received from this program.

_________________________________________ ______________________________
Signature Date

Adopted: 9/06
Revised: 09/14
TYPE OF ENERGY ASSISTANCE NEEDED:

☐ Electric   ☐ Propane   ☐ Kerosene/ Diesel Monitor Heater   ☐ Pellets

☐ Wood       Length of Wood ____ inches        Preference: Hardwood or Fir (circle)

☐ Elders or Disabled Adults do you need assistance in stacking your wood? (Check one)
   YES_____   NO_____

Name of Vendor for Energy Assistance:_____________________________________________

Account Number:_____________________________________________

LIHEAP
FAIR HEARING STATEMENT

Client Rights- If you wish to appeal any decision regarding your application.

❖ If you feel the decision of the LIHEAP Intake Staff is in error, you may file a written appeal within ten (10) days after receiving a letter of denial to the Social Services Director.

❖ The Social Services Director will review and make a decision regarding your appeal within five (5) days after receiving your written appeal.

❖ If the Social Services Director upholds the initial decision, you have ten (10) days after receiving their written decision to file a written appeal to the Yurok Tribal Council. The Yurok Tribal Council then has ten (10) days to receive their final written decision by mail.

I have read the above rights and have been advised of my rights to appeal any decision made by the LIHEAP Intake Staff.

________________________________________  ________________________________
Signature of Applicant                      Date

Adopted: 9/06
Revised: 09/14
LIHEAP
RESPONSIBILITY STATEMENT

I, ____________________________________________, reside at
Print Name

_________________________________________________________________  __________________________
Physical Address        City    State    Zip

My utility bill is in the name of ________________________________, I am
responsible for payment of the utility bill for the above address.

If the bill is not in your name, you are responsible for payment of the utility bill for
the above address because:
_________________________________________________________________
_________________________________________________________________

He/She is my _____________________________________________________________________.

*I certify that all information is true and correct to the best of my knowledge.

__________________________________________  __________________________
Applicant Signature            Date