K'ima:w Medical Center
An Entity of the Hoopa Valley Tribe
Low Income Home Water Assistance Program
P.O. Box 1288 Hoopa, CA 95546
PH: 530-625-4261 FAX: 530-625-4858

LIHWAP 2021-2022

Your application for Low Income Home Water Assistance Program (LIHWAP) will not be processed without the proper documentation. Please make sure your application is complete prior to submitting it to K'ima:w Medical Center staff. Please use the checklist below.

If you are disabled or have a medical condition that requires a specific energy need, you must provide supporting documentation. All disabilities must be in accordance with State Disability or the Social Security Administration guidelines.

LIHWAP Application Checklist

_____ **Completed Application**

_____ **Proof of Income for all Household members**

_____ **Current Water Bill** **(If applying for Crisis Assistance, must provide proof of disconnection, shut off notice, or past due balance)**

_____ **Proof of Physical Address**

_____ **Proof of Tribal Verification**

_____ **Proof of Handicap/Disability (*only if claiming Disability*)**

_____ **Zero Income Verification *(only if claiming Zero Income)***

APPLICANT NAME:_____

K'ima:w Medical Center - An Entity of the Hoopa Valley Tribe
FY 2021-2022 LIHWAP Application

Applicant: _____ Date:_____
Address (P.O. Box): _____ S.S.#: _____
City, State: _____ DOB: _____
Physical Address: _____ Phone #: _____
_____ Roll #: _____

ELIGIBILITY INFORMATION

Please list all members in your household including yourself.
Include proof of income for all members of your household (if they receive any).

Name:	Relationship:	Date of Birth:	Age:	Disabled Yes or No:	Monthly Income:	Source of Income:
	Self					

Total Household Monthly Income: $_____ Total Number in Household : _____

WATER ASSISTANCE REQUESTED

Crisis **Non-Crisis**
Terminated Service/Shut Off Notice/Past Due

I hereby authorize K'ima:w Medical Center - An Entity of the Hoopa Valley Tribe's LIHWAP representative to examine and verify all information submitted for my application for payment under the LHWAP Program. I hereby authorize my utility supplier(s) to release information on my account (past and future) to the above named LIHWAP program. I understand that this information is confidential. No information obtained through this release shall be made public so that the dwelling or occupants may be identified. I understand that my application will not be processed unless all required documentation is submitted. I also certify that the above information is true and correct to the best of my knowledge.

_____ _____
Applicant Signature Date

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ZERO INCOME VERIFICATION

If you are claiming zero income please fill out this form

I, _____, hereby certify that I had zero income for the year.

Please list the name/resource of how you were provided with the following:

1. Housing: (Where did you live/who provided housing/etc)
   _____
2. Food: (Did you receive food-stamps/commodities/etc)
   _____
3. Utilities: _____
4. Medical: _____
5. Transportation: _____
6. Clothing: _____
7. Comments: (or you may provide further information regarding living and/or income status, or explain your zero income situation more thoroughly)
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

By signing this document I am certifying that all information provided orally and on this application form is true to the best of my knowledge. I acknowledge that such information is subject to verification and that falsification of this information shall be grounds for termination form any program in which I participate and that I may be subject to prosecution under the law. I further give permission for K'ima:w Medical Center - An Entity of the Hoopa Valley Tribe to verify the above statements with County Welfare, Unemployment or any other services agencies.

Applicant Signature: _____ Date: _____

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PROOF OF ENERGY BURDEN

Please list your monthly energy expenses. You need to provide proof of each expense that you are claiming. For example, if you are claiming you pay $100.00 for propane per month, you need to provide a copy of your propane bill. By providing this information, you may qualify for a higher amount of funding.

	Energy Source:	**Current Monthly Expense (if any):**
1	WOOD	
2	PROPANE	
3	OIL	
4	GAS/KEROSENE	
5	ELECTRICITY	

**** An energy burden is your total energy expenses for one month (or year) divided by your monthly (or annual) income. For example: if your monthly income was $1000 and your electricity bill was $100, your propane, $100 and your kerosene $200 for one month then your total energy burden would be $400 for that month. $400 divided by $1000 is .40, which is equal to 40%.*

I certify that the information I have provided is true and correct to the best of my knowledge. I am aware that willfully and knowingly falsifying information may lead to criminal prosecution and termination of services from K'ima:w Medical Center - An Entity of the Hoopa Valley Tribe's LIHWAP Program. I hereby authorize K'ima:w Medical Center's LIHWAP representative to examine and verify all information submitted for my application for payment under the LIHWAP Program. I hereby authorize my utility supplier(s) to release information on my account (past and future) to the above named LIHWAP program. I understand that this information is confidential. No information obtained through this release shall be made public so that the dwelling or occupants may be identified. I understand that my application will not be processed unless all required documentation is submitted.

_____ _____

Applicant's Signature Date

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby authorize and request that K'ima:w Medical Center's LIHWAP Program may release and/or exchange all confidential professional information pertaining to me (or my minor children) to the following individuals and agencies:

- ☐ All Courts (Tribal, Federal, State, & County)
- ☐ TANF: _____
- ☐ Social Services/DHS (Local & County)_____
- ☐ ICW/CWS/CPS: _____
- ☐ Housing Authority: _____
- ☐ Education/School: _____
- ☐ Employment Development Department _____
- ☐ K'IMA:W Medical Center: _____
- ☐ Other Medical Facilities: _____
- ☐ Other: _____

I understand that this Release of Information will remain in effect for one (1) year and that I may revoke this consent at any time by informing the above parties in writing. My signature below indicates I have read and thoroughly understand the terms of this consent for release of confidential information. By signing this Consent for Release of Information I hereby release K'ima:w Medical Center's LIHWAP Program and its agents and employees from any and all liabilities, responsibilities, damages and claims which might result from release of information authorized above.

_____ _____
Applicant Signature Date

_____ _____
LIHEAP Program Representative Date

Fair Hearing Statement

Client Appeal Rights:

If your application for assistance is denied or you feel your application was not handled in an efficient or timely manner, you may do the following;

- File a written appeal within ten (10) days of receiving a letter of denial to the CEO of K'ima:w Medical Center.
- The CEO of K'ima:w Medical Center will review your information and make a decision regarding your appeal within five (5) days of receiving your written appeal.
- If you are unhappy with K'ima:w Medical Center CEO's decision, final appellate authority rests with the K'ima:w Medical Center Board of Directors.

I have read and understand my appeal rights.

_____ _____
Applicant Signature Date

Responsibility Statement

I, _____, reside at _____
(Print name) *(Physical address)*

My utility bill is in the name of: _____, he/she is my _____. I am responsible for payment of the utility bill for
(Relationship)
the address above.

By signing this document, I certify that all information is true and correct to the best of my knowledge. I acknowledge that all information is subject to verification and I also understand that falsification of any information shall be grounds for termination K'ima:w Medical Center - An Entity of the Hoopa Valley Tribe's LIHWAP program.

_____ _____
Applicant Signature Date