

APPLICATION COVER SHEET – WATERLOO UTILITY ASSISTANCE



**** INCOMPLETE APPLICATIONS WILL BE DENIED ****

*****PLEASE CALL IF YOU NEED ASSISTANCE COMPLETING THIS APPLICATION*****

Black Hawk County Office 1535 Lafayette St. Box 4120 Waterloo, IA 50704 319-291-2065	Buchanan County Office 1827 1 st St. W, Ste D Independence, IA 50644 319-334-6081	Grundy Center Office 1606 G Avenue Grundy Center, IA 50638 319-824-3460
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Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Email: _____ Phone: _____ Last 4 of Social Security #: _____

UTILITY ASSISTANCE (This application only assists Waterloo Households)

- Are you late on your utility bill or have you received a Disconnect Notice? Yes No
- What bill are you late on? Water Energy/Electric/Gas
- Have you applied to any other agencies for assistance with this bill? Yes No

If yes, where: _____

How much Assistance do you Need?	
Water/Sewer	\$ _____
Energy	\$ _____

- ✓ COMPLETE THE BASIC INTAKE FORM
- ✓ ATTACH PROOF OF INCOME (See Income Attachment)
- ✓ ATTACH COPY OF BILL
- ✓ ATTACH CONSENT TO RELEASE & EXCHANGE INFORMATION
- ✓ PROVIDE SOCIAL SECURITY CARD COPIES (IF NOT PREVIOUSLY PROVIDED TO OT)

Is your need for assistance related to the COVID-19 Pandemic? _____ Yes _____ No

If yes, how? Check all that apply.

- Unemployed / Job Loss Unable to Work due to COVID-Related Health Risks
 Reduction in Hours Other: _____

My signature below certifies that the income on this application is true and correct to the best of my knowledge. I understand any false information may disqualify me for assistance.

APPLICANT SIGNATURE: _____

DATE: _____

FOR OFFICE USE ONLY

Application Status: Approved Denied Reason: _____

Amount Paid by OT: _____ Agency/Vendor to Pay: _____

QUESTIONS? CALL US OR EMAIL CRISIS@OPERATIONTHRESHOLD.ORG



OPERATION THRESHOLD

CONSENT TO RELEASE, OBTAIN OR EXCHANGE INFORMATION

Participant Name: _____ Date of Birth: _____

Address: _____

FROM: Name: 1535 Lafayette Street Waterloo, IA 50703 PH (319) 291-2065 FAX (319) 232-6484	TO: Agency: Contact Person: Address: Phone: _____ FAX: _____
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CONSENT TO OBTAIN OR EXCHANGE THE FOLLOWING CHECKED ITEMS

HOUSING ASSISTANCE <input type="checkbox"/> Rent <input type="checkbox"/> Deposit <input type="checkbox"/> Mortgage <input type="checkbox"/> Homelessness	UTILITY ASSISTANCE <input type="checkbox"/> Water <input type="checkbox"/> Gas <input type="checkbox"/> Electric <input type="checkbox"/> Fuel	EMPLOYMENT EXPENSES <input type="checkbox"/> Equipment <input type="checkbox"/> Clothing
BILL ASSISTANCE <input type="checkbox"/> Landline Phone <input type="checkbox"/> Cell Phone	EXPENSES <input type="checkbox"/> Medical Bills <input type="checkbox"/> Dental Bills	EDUCATION <input type="checkbox"/> Books <input type="checkbox"/> Materials
ASSISTANCE FOR CHILDREN <input type="checkbox"/> Internet for School <input type="checkbox"/> School Uniforms/School Clothing <input type="checkbox"/> Child Care		TRANSPORTATION <input type="checkbox"/> Bus Pass <input type="checkbox"/> Vehicle Registration
HOUSEHOLD ASSISTANCE <input type="checkbox"/> Household Items <input type="checkbox"/> Personal Hygiene <input type="checkbox"/> Food <input type="checkbox"/> Personal Protective Equipment (PPE)		OTHER:

Briefly explain the purpose for this release of information	To communicate with Vendor/Agency who will receive payment by verifying any necessary information for the above selected program assistance.
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Please read before signing below.

*I understand that the consent to Release, Obtain or Exchange Information form is limited to the agencies, groups or persons named, and this information is not to be passed on to anyone else or to be used for any purpose other than those specified.

*I understand that I have the right to see this information at any time. I can revoke my consent by writing to both the persons giving and the persons receiving the information. But any information already released may be used as stated on this consent. I understand the information is needed to plan services or to determine eligibility for services. This consent is not automatically renewable. It expires automatically at the end of the period specified unless revoked sooner. I have read this release form, or it has been read to me and I understand its content.

*Federal and/or State law specifically requires that any disclosure or re-disclosure of AIDS-related information must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

<input checked="" type="checkbox"/> This authorization is a one-time disclosure and is valid for 90 days from the date of signature <input type="checkbox"/> This authorization becomes invalid one year from date of signature or when case is closed

See also Chapter 228 of the Iowa Code and Section 141.23(3) of the Iowa Code and other applicable laws.

Participant Signature	Effective Date
Staff Signature	Date

Please check and initial one of the below:

<input type="checkbox"/> I declined a copy of this release: _____ Participant Initials	<input type="checkbox"/> I received a copy of this release: _____ Participant Initials
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INCOME ATTACHMENT: WHAT INCOME DOCUMENTATION DO I NEED TO PROVIDE?



Please provide documentation for all income types that you have, including your Bank Account Checking/Savings history. It is the responsibility of the applicant to obtain and submit the required income documentation with the application.

If you have no income, you must request a Minimal Income Verification Form from our staff.

CHECKLIST (for Office Use only)	DOCUMENTATION TO SUBMIT WITH APPLICATIONS	
	IF YOU HAVE THIS INCOME	YOU NEED TO PROVIDE THIS DOCUMENTATION....
	Employment/ Wages	Last THREE Months of pay stubs for each employed person in the Household, 18 and over.
	Checking Account	Last SIX Months of Statements. Must not black out any part of bank statement.
	Savings Account	Last THREE Months of Statements. Must not black out any part of bank statement.
	Social Security / SSI / SSDI	Attach your most recent benefit letter for the current year
	Welfare Assistance / FIP	Attach verification for any public assistance programs
	Alimony / Child Support	Child support (amount received in the last THREE Months) and documentation of Alimony from court order
	Unemployment, Severance, Workers Comp	Verification of past THREE Months
	VA/IPERS/ Civil Service/ IRA/ Annuities	Attach the most recent benefit for the current year
	Rental Property Income	Last TWO Years of income tax statements (certified copy from IRS or Tax Preparer)
	Pensions	Attach the 1099 form from pension providers for the last year
	Gifts	Attach documentation for financial assistance received from an individual
	Income from a Business	Attach tax statements from the business for the past TWO years
	Other Real Estate	Indicate address and value of the asset
	Life Insurance	Cash Value Only
	Retirement, 401k, Keogh Accounts	Attach statement showing current value
	Other	Attach any copies of other income or asset verification

If you have questions about what type of information to provide, please contact our office or 319-291-2065 or email Crisis@operationthreshold.org

INCOMPLETE APPLICATIONS WILL BE DELAYED / DENIED

DUPLICATION OF BENEFITS CERTIFICATION

This certification must be completed by all applicants that will receive assistance from the CDBG-CV funded Crisis Assistance programs, offered by Operation Threshold. CDBG-CV funds follow The Robert T. Stafford Disaster Relief and Emergency Assistance Act, (42 U.S.C. 5121-5207) (Stafford Act) Section 312 which prohibits federal agencies from providing assistance to any person, business concern or other entity for "any part of such loss as to which one has received financial assistance under any other program or from insurance or any other source." 42 U.S. C. 5155(a) and Economic Security Act.

Please identify any other assistance funds that you have received or anticipate receiving for this need. Sources of funds include but are not limited to Federal, State, and local government, church, or nonprofit assistance programs.

I/We have received the following recovery assistance funds:

ASSISTANCE / AGENCY	AMOUNT	USE OF FUNDS

No members of the household have received any type of assistance for this need in the past three months.

I hereby certify that:

1. I/We have received no other assistance funds for this assistance request, together than those set forth above.
2. If I/We receive duplicated benefits, I/we will repay the duplicated benefits.
3. I/We certify under penalty of perjury that all information provided as part of this application is true and correct to the best of My/Our knowledge.

Printed Name

Signature

Date: _____



BASIC INTAKE FORM

HEAD OF HOUSEHOLD CONTACT INFORMATION							
LAST NAME		FIRST NAME		MIDDLE INITIAL		COUNTY	
STREET ADDRESS		CITY		STATE		ZIP CODE	
MAILING ADDRESS		CITY		STATE		ZIP CODE	
HOME PHONE NUMBER		CELL NUMBER		EMAIL ADDRESS			

HOUSEHOLD MEMBER INFORMATION (A legend for completing this section is at the bottom of the page)

NAME (FIRST AND LAST) USE ROW 1 FOR PERSON LISTED ABOVE	RELATION TO HEAD OF HOUSEHOLD	Marital Status	DATE OF BIRTH	GENDER (circle one)	SOCIAL SECURITY NUMBER OR I-94 NUMBER	DISABILITY (circle one)	HEALTH INSURANCE	HISPANIC, LATINO, OR OF SPANISH ORIGIN?	RACE	MILITARY STATUS (circle one)	HIGHEST LEVEL OF EDUCATION	EMPLOYMENT (work status)	INCOME PERIOD
1	HEAD OF HOUSEHOLD			MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
2				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
3				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
4				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
5				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
6				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
7				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
8				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			

HOW MANY HOUSEHOLD MEMBERS ARE: A U. S. Citizen _____ Homebound _____ **A disconnected youth (age: 14-24) who is neither working or in school** _____

LEGEND FOR COMPLETING THE HOUSEHOLD MEMBER SECTION

RELATION TO HH	DOB	MARITAL STATUS	SS NUMBER OR I-94 NUMBER	HEALTH INSURANCE	RACE	HIGHEST LEVEL OF EDUCATION	EMPLOYMENT (WORK STATUS)
<ul style="list-style-type: none"> Head of Household Spouse Child Foster Child Grandchild Sibling Parent Grandparent Other Relative Not Related 	<ul style="list-style-type: none"> Date Format 99/99/99 	<ul style="list-style-type: none"> Married Single Divorced Widowed 	<ul style="list-style-type: none"> Social Security Number Format: 999-99-9999 I-94 Format (11 numbers) 999999999 99 <p>INCOME PERIOD</p> <ul style="list-style-type: none"> Weekly Bi-Weekly Semi-Monthly Monthly Quarterly Annually 	<ul style="list-style-type: none"> Medicaid Medicare State Children's Health Insurance Program State Health Insurance for Adults Military Health Care Direct Purchase Employment Based None 	<ul style="list-style-type: none"> American Indian Alaska Native Asian White Black or African American Native Hawaiian and Other Pacific Islander Other Multi-Race 	<ul style="list-style-type: none"> 0-8th Grade 9th-12th Grade/non-graduate High School Graduate (or equivalency diploma) 12th Grade + some post-secondary school College Graduate (2 or 4 year) Graduate of other post-secondary school 	<ul style="list-style-type: none"> Employed (Full-Time-FT) Employed (Part-Time-PT) Migrant Seasonal Farm Worker Unemployed (short-term, 6 months or less) Unemployed (long-term, more than 6 months) Unemployed (not in labor force) Retired

3. HOUSEHOLD TYPE (check one)

<input type="checkbox"/> Single Person	<input type="checkbox"/> Single Parent Female	<input type="checkbox"/> Single Parent Male	<input type="checkbox"/> Two Parent Household
<input type="checkbox"/> Two Adults No Children	<input type="checkbox"/> Multi-Generational Household	<input type="checkbox"/> Non-Related Adults with Children	<input type="checkbox"/> Other

4. HOUSEHOLD INCOME SOURCES (check all that apply)

For each household income source you check, you must include proof of income documentation with this application. For EMPLOYMENT INCOME, provide copies of your check stubs for the 30 days preceding this application, or provide a copy of your federal income tax return. For SELF-EMPLOYMENT INCOME or FARM INCOME, provide a copy of your federal income tax return.

<input type="checkbox"/> Employment Income (salary/wages)	<input type="checkbox"/> SSI (Supplemental Security Income)	<input type="checkbox"/> Private Disability Insurance	<input type="checkbox"/> SSDI (Social Security Disability Income)
<input type="checkbox"/> Self-Employment or Farm Income	<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> Alimony or Spousal Support	<input type="checkbox"/> Social Security Retirement Income
<input type="checkbox"/> VA Service Connected Disability Compensation	<input type="checkbox"/> Child Support	<input type="checkbox"/> General Relief/Assistance	<input type="checkbox"/> Unemployment Insurance/Benefits
<input type="checkbox"/> VA Non-Service Connected Disability Compensation	<input type="checkbox"/> Pension	<input type="checkbox"/> TANF/FIP Assistance	<input type="checkbox"/> No Income
<input type="checkbox"/> Other:			

Does your household have savings over \$50,000 (include: all savings and checking accounts, CDs, and other investments)? YES NO
Did anyone in your household file a tax return and receive the EITC (Earned Income Tax Credit) benefit last year or this year? YES NO

HOUSEHOLD NON Cash Benefits (Check all that apply)

<input type="checkbox"/> WIC (Women, Infants & Children)	<input type="checkbox"/> Public Housing	<input type="checkbox"/> Permanent Supportive Housing	<input type="checkbox"/> LIHEAP	<input type="checkbox"/> Affordable Care Act Subsidy	<input type="checkbox"/> SNAP (Food Stamps)
<input type="checkbox"/> Housing Choice Voucher (HCV)	<input type="checkbox"/> HUD-VASH Veteran's Affair Supportive Housing	<input type="checkbox"/> Child Care Voucher	<input type="checkbox"/> Other _____		

HOUSING STATUS (check one) OWN RENT OTHER PERMANENT HOUSING HOMELESS (if homeless, what is your housing status?) OTHER **What are your Mortgage or Rent costs per month?** \$

- If you rent, are your heating costs included in your rent? Yes No
- If you Rent, do you receive RENT assistance? Yes No
- If you Rent, if your rent based on a percentage of your income? Yes No

HOUSING TYPE

House Mobile Home Rent a Room 2, 3, or 4 Unit Apt. 5 or more Unit Apt. Other

IF YOUR HEAT IS INCLUDED IN YOUR RENT, YOU MUST INCLUDE A COPY OF YOUR LEASE.

LANDLORD/COMPLEX INFORMATION

NAME	ADDRESS	PHONE
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MAIN SOURCE OF HOME HEATING You must include copies of your most recent Heating Bill and Electric Bill.

Natural Gas Electric Propane (LP) Fuel Oil Wood/Coal/Corn Other

* If propane or fuel oil, do you have an empty tank (20% or less or in the red)? Yes No

DO YOU HAVE A DISCONNECT NOTICE? YES NO
ARE YOU CURRENTLY DISCONNECTED? YES NO

*** Please provide copy of disconnect notice with application.**

HOUSEHOLD HEATING AND ELECTRIC COMPANIES

Heating Vendor	Electric Vendor
Account Name	Account Name
Account Number	Account Number

CERTIFICATION STATEMENT

I certify under penalty of perjury the above information is true. I give permission to the agency processing this application to acquire additional information and to share information with other organizations for the purposes of providing services to assist my household. This sharing of information is to be conducted with maximum respect for the confidentiality of the information contained in this application.

I am hereby making application for assistance to Operation Threshold for any of the following programs: LIHEAP, CSBG, CDBG, HOME, EFSP. **I further certify the following:** I declare that I am the only person in the household who has or will apply for this program(s). I understand that this information will be used, upon request, in determining eligibility for other agency programs or services. Any willful misrepresentation of the information on this form is subject to a penalty of law. I assure that any payments received will be used solely for the needs stated on my application and verified by Operation Threshold Staff. I understand that by signing (either in written form or electronically) this application, I am authorizing the assistance to be provided and vendor to be paid.

I hereby give permission to the State of Iowa, the U.S. Department of Energy, U.S. Department of Health and Human Services, U.S. Department of Housing and Urban Development and the agency processing this application to obtain additional information as relevant to completing and verifying my application for assistance. This includes permission to the State of Iowa to release application information to my energy supplier and to provide details about my account and energy use to the LIHEAP and Weatherization Assistance Program.

I understand this statement.

APPLICANT SIGNATURE

DATE