

TRIBAL WEATHERIZATION

District 4 HRDC
Weatherization Program
2229 5th Avenue
Havre, MT 59501
406-265-6743

- Fort Belknap Rocky Boy

WEATHERIZATION PROGRAM APPLICATION

Please provide a copy of your LIEAP Eligibility Paperwork

Household Address Information:

This application is for weatherization for the dwelling resided in at the time of application.

If there is a move before approval is made, you must re-apply.

Physical Street Address		Mailing Address	
City	State	Home Phone	Cell Phone

Living on the Reservation: Yes No **Tribal Member:** Yes No

HOUSEHOLD INFORMATION

Last Name	First Name	Middle I	Social Security Number (SSN)	Relationship to Head of Household	Age	Gender
1				HEAD		
2						
3						
4						
5						
6						
7						
8						
9						
10						

Total Number of Persons in home: _____

ONLY COMPLETED AND SIGNED APPLICATIONS WILL BE PROCESSED

Do you? Own Rent **If renting, please provide the following:**

Landlord Name: _____ Phone No: _____

Address: _____ City/State/Zip: _____

TRIBAL WEATHERIZATION

Housing Type: (Please check one)

- House Mobile Home Apartment/Duplex

Number of Bedrooms: (Please check one)

- One Two Three Four or more

What type of heat does your household use as your main heat source?

- Natural Gas Propane Coal Electricity Wood Fuel Oil

Who is your main heat vendor?

- NorthWestern Energy Other _____ Account Number: _____

RELEASE OF CONFIDENTIAL INFORMATION

AUTHORIZATION TO MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES TO OBTAIN PERSONAL INFORMATION: I authorize any individual, company, agency, or other entity which has information about me or my household, including but not limited to the information sources listed below to release or disclose information to the Montana Department of Public Health and Human Services (DPHHS) and /or to any agent or contractor of the DPHHS which is authorized to determine eligibility for Energy Assistance or Weatherization benefits. I authorize the disclosure or release of any information relevant to my eligibility for Energy Assistance or Weatherization benefits, including but not limited to the information to be released or disclosed listed below. I understand any information obtained will be kept confidential and will be used only for the purposes directly connected with the administration of benefits or services and only during the pertinent time period. I further understand that any information obtained may be released or disclosed to a proper government agency, court of law, or law enforcement agency for purposes of legal investigative actions concerning fraud. I further understand that information contained on this application can be used in DPHHS electronic databases for the determination of eligibility for programs and/or to record services provided to my household for federal and /or state reporting purposes.

INFORMATION SOURCE: Banks, Savings & Loans, Credit Unions, Employers, Social Security Administration, Veterans Administration, State Department of Labor and Industry, Internal Revenue Services, State Department of revenue, State compensation Insurance Fund, Unemployment Compensation Division, County Clerk & Recorder, Bureau of Indian Affairs, Utility Suppliers and Vendors, Other Social Services Providers, Landlord, Child Support Enforcement Division, Offices of Public Assistance.

INFORMATION TO BE RELEASED OR DISCLOSED: Savings, Certificated of Deposit, Stocks & Bonds, Safety Deposit Boxes (to be opened only in the presence of the client or his agent and representatives of the financial institution), Gross Earnings, Social Security Payments, V.A. Benefits, Personal and Business Income, Workers compensation, Unemployment compensation, Family Composition, Size of Home, Per Capita Payments, Lease Payments, Indian Income Maintenance (IIM) Accounts, Amount of fuel Assistance Received from agencies, Utility Billing Information, Child Support Payments, Benefit Information.

Signature of head of household or person signing on his/her behalf:

X _____ Date: _____ SSN: _____

Signature of all other household members age 16 or older:

X _____ Date: _____ SSN: _____

X _____ Date: _____ SSN: _____

X _____ Date: _____ SSN: _____

X _____ Date: _____ SSN: _____

X _____ Date: _____ SSN: _____

X _____ Date: _____ SSN: _____

X _____ Date: _____ SSN: _____

X _____ Date: _____ SSN: _____

DISTRICT 4 HUMAN RESOURCES DEVELOPMENT COUNCIL

2229 5TH AVENUE HAVRE, MT 59501
 PHONE: (406) 265-6743 FAX: (406) 265-1312



AGENCY INTAKE FORM

FOR OFFICE USE ONLY		Household Last Name Starting Initial (A, B, etc.)
HH # _____	Date Entered _____	
Program: WEATHERIZATION		
Staff: _____		

HOUSEHOLD ADDRESS INFORMATION			Street Address:		Mailing Address:			County	
City:			State:		Zip:		Housing: <input type="checkbox"/> Multi Family <input type="checkbox"/> Single Family <input type="checkbox"/> On Reservation <input type="checkbox"/> Mobile Home <input type="checkbox"/> None		
Home Phone:			Work Phone:		Message Phone:			Contact Name:	
Email Address:									

HOUSEHOLD MEMBER INFORMATION

LAST NAME,	FIRST NAME	MI	SOCIAL SECURITY NUMBER	RELATIONSHIP TO HEAD OF HOUSHOLD	BIRTH DATE M / D / YR	Sex	RACE CODE BELOW	TRIBAL MEMBER YES/NO	VETERAN YES/NO	DISABLED YES/NO	HEALTH INSURANCE CHECK ALL THAT APPLY	IN LITERACY TRAINING YES/NO	IN SCHOOL YES/NO	EMPLOYMENT STATUS CODES BELOW	LAST GRADE COMPLETED
				SELF/ HEAD OF HOUSE	/ /	M F					<input type="checkbox"/> HMK <input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> PRIVATE <input type="checkbox"/> NONE				
					/ /	M F					<input type="checkbox"/> HMK <input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> PRIVATE <input type="checkbox"/> NONE				
					/ /	M F					<input type="checkbox"/> HMK <input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> PRIVATE <input type="checkbox"/> NONE				
					/ /	M F					<input type="checkbox"/> HMK <input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> PRIVATE <input type="checkbox"/> NONE				
					/ /	M F					<input type="checkbox"/> HMK <input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> PRIVATE <input type="checkbox"/> NONE				
					/ /	M F					<input type="checkbox"/> HMK <input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> PRIVATE <input type="checkbox"/> NONE				
					/ /	M F					<input type="checkbox"/> HMK <input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> PRIVATE <input type="checkbox"/> NONE				

RACE CODES:	N = Native American/Alaskan	A = Asian or Pacific Islander	B = Black/Not Hispanic	H = Hispanic	W = White – Not Hispanic	O = Other	U =Unknown
EMPLOYMENT STATUS CODES:	N = Not Employed	F = Full-Time Employment	P = Part-Time Employment	R = Retired/Not Working			

HRDC does not discriminate against any person on the basis of age, sex, race, religion, national origin, sexual orientation, gender identity or disability with respect to employment, volunteer participation or the provision of services.
 (Form Revised 10/22/2012)

GROSS INCOME AND BENEFITS OF ALL HOUSEHOLD MEMBERS

Check all income sources that apply to any/all members of your household.

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Employment/Wages | <input type="checkbox"/> TANF (AFDC, FAIM) | <input type="checkbox"/> Medicare | <input type="checkbox"/> Interest Income | <input type="checkbox"/> Odd Jobs _____ |
| <input type="checkbox"/> Self Employment | <input type="checkbox"/> General Assistance | <input type="checkbox"/> Social Security | <input type="checkbox"/> Rental Income | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Unemployment | <input type="checkbox"/> SSI | <input type="checkbox"/> Child Support/Alimony | <input type="checkbox"/> Educational Grants | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Worker's Comp | <input type="checkbox"/> SNAP (Food Stamps) | <input type="checkbox"/> VA | <input type="checkbox"/> Retirement Income | |

Enter the requested information for all household members, regardless of age or relationship.

Household Member	Wages, Salaries, etc.	Social Security, Pensions, Etc.	Public Assistance (list type)	Other Income (list amount & type)
	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	
	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	
	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	
	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	
	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	
	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	
	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	

READ CAREFULLY BEFORE SIGNING.
IF YOU DO NOT UNDERSTAND SOMETHING, ASK YOUR HRDC STAFF WORKER

- The collection of personal information on program participants is essential to the provision of services at District 4 HRDC: information is collected and stored in the agency Central Database System. Information may be used by HRDC programs to determine eligibility. I further understand that information contained on this application can be used in DPHHS electronic database for the determination of eligibility for programs and/or to record services provided to my household for federal and/or state reporting purposes. If you have questions or need help filling out this form please speak to you HRDC case manager or staff providing you with assistance.
- The information I (we) give here is subject to verification by HRDC staff. If false information is knowingly provided eligibility for services may be jeopardized.
- I certify that all my answers are correct and complete to the best of my knowledge, including information about each household member.

Head of Household Signature _____ Date ____ / ____ / ____



STAFF MEMBER PLEASE PRINT LAST NAME HERE: _____