



APPLICATION FOR THE FLORIDA LOW-INCOME HOUSEHOLD WATER ASSISTANCE PROGRAM (LIHWAP)

PLEASE FILL OUT APPLICATION COMPLETELY : Your LIHWAP application is not a commitment that your bill will be paid. If eligible, a credit will be sent directly to the utility vendor. However, you must continue to pay the amount owed on your bill. LIHWAP applications should be submitted to the local LIHWAP provider for your Florida county listed at the link provided below OR via email to LIHWAP@commerce.fl.gov or if you prefer you may fax to (850) 208-6801 <https://www.floridajobs.org/community-planning-and-development/community-services/low-income-household-water-assistance-program/find-your-local-low-income-household-water-assistance-program-provider-for-help>

1 Please complete this section for the head of household. ***Use the codes from question 2 to help provide the details.**

Name (Include Last, First Middle Initial)		Date of Birth (MM/DD/YY)	Sex (M/F)	Social Security Number
Home Address (Include Street, Apt. Number, City, State & ZIP Code+4)				
Mailing Address if different (Include Street, Apt. Number, City, State & ZIP Code+4)				
County You Live In	Phone Number: ()	Citizenship*	Race*	Ethnicity*
Are you Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you receive Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If you are currently receiving Cash, Medical Assistance, or SNAP benefits, may we use the income you have on file? <input type="checkbox"/> Yes <input type="checkbox"/> No				

2 List the people who live with you at this address. Include all children and adults. Include related roomers.

Use the codes below to help provide the details for each individual in your household.

CITIZENSHIP* : (1) U.S. Citizen/Nationalized, (2) Not U.S. Citizen/Alien lawfully admitted for permanent residence, (3) Cuban Entrant, (4) Lawfully Admitted Alien/Refugee, (5) Haitian Entrant, (6) Others.

RACE* : (1) American Indian/Alaskan Native, (2) American Indian/Alaskan Native & Black/African American, (3) American Indian/Alaskan Native & White, (4) Asian, (5) Asian & White, (6) Black/African American, (7) Black/African American & White, (8) Native Hawaiian/Pacific Islander, (9) Other Multi-Racial, (10) White, (11) Decline to Report.

ETHNICITY* : (1) non-Hispanic, (2) Hispanic

Name (Include Last, First, Middle Initial)	Birthdate (MM/DD/YY)	Sex M/F	Social Security Number	Citizenship*	Race*	Ethnicity*	Relationship to You
Are you Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you receive Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If this person is currently receiving Cash, Medical Assistance, or SNAP benefits, may we use the income we have on file for this person? <input type="checkbox"/> Yes <input type="checkbox"/> No							

Name (Include Last, First, Middle Initial)	Birthdate (MM/DD/YY)	Sex M/F	Social Security Number	Citizenship*	Race*	Ethnicity*	Relationship to You
Are you Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you receive Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If this person is currently receiving Cash, Medical Assistance, or SNAP benefits, may we use the income we have on file for this person? <input type="checkbox"/> Yes <input type="checkbox"/> No							

Name (Include Last, First, Middle Initial)	Birthdate (MM/DD/YY)	Sex M/F	Social Security Number	Citizenship*	Race*	Ethnicity*	Relationship to You
Are you Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you receive Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If this person is currently receiving Cash, Medical Assistance, or SNAP benefits, may we use the income we have on file for this person? <input type="checkbox"/> Yes <input type="checkbox"/> No							

Name (Include Last, First, Middle Initial)	Birthdate (MM/DD/YY)	Sex M/F	Social Security Number	Citizenship*	Race*	Ethnicity*	Relationship to You
Are you Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you receive Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If this person is currently receiving Cash, Medical Assistance, or SNAP benefits, may we use the income we have on file for this person? <input type="checkbox"/> Yes <input type="checkbox"/> No							

Name (Include Last, First, Middle Initial)	Birthdate (MM/DD/YY)	Sex M/F	Social Security Number	Citizenship*	Race*	Ethnicity*	Relationship to You
Are you Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you receive Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If this person is currently receiving Cash, Medical Assistance, or SNAP benefits, may we use the income we have on file for this person? <input type="checkbox"/> Yes <input type="checkbox"/> No							

****If you have additional people in your house, please provide their information on a separate piece of paper and send it along with this application****

- 3** Tell us about income for the people in your household. Please tell us about all income, before taxes and deductions. Types/sources of income include money from: (**Monthly Income, Monthly social Security Income, Monthly Alimony Income, Monthly State Reemployment Assistance, Monthly Pension Income, Monthly Workers Compensation Income, Monthly Self Employment Income, Monthly Supplemental Nutrition Assist (SNAP), Monthly Supplemental Security Income (SSI), Monthly Temp Assist for Needy Families (TANF), Monthly Means Tested Veteran Program and Other Monthly Income**):

Name of person with income	Type/source of income	How much each month?
Name of person with income	Type/source of income	How much each month?
Name of person with income	Type/source of income	How much each month?
Name of person with income	Type/source of income	How much each month?
Name of person with income	Type/source of income	How much each month?

- 4** What is your current housing status? Rent? Own this home?

- 5** Do you Live in a government subsidized housing complex, Section 8 housing, dormitory, nursing home, adult foster home or any kind of group living facility? **Yes** **No**

Name of the place where you live :
Address (Include Street, Apt. Number, City, State & ZIP Code:
County:

- 6** If your monthly income is less than 60% of the Florida state median income (SMI) (*Or if the number of your household members is nine (9) or greater, 150% of the Federal poverty guidelines (FPG), explain how you pay for food, shelter, clothing, transportation, and home utilities.

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- 7** Complete the following for your household:

Number of elderly persons (65 or older):	
Number of disabled persons:	
Number of children 5 years of age or younger:	

- 8** If you share your living or mailing address with others who are not part of your home, list their names

8a.
8b.
8c.

9 If you or anyone in your home are not a U.S. citizen or alien lawfully admitted for permanent residence, give the person's name and alien status under the Immigration and naturalization Act.

Name:	Alien Status:
9a.	9b.
9c.	9d.
9e.	9f.

10 You, or a member of my household, is currently receiving benefits from the Low- Income Home Energy Assistance Program (LIHEAP) **Yes** **No**

11 Do any of the following situations currently apply to you? (Check appropriate box(es) below)

- My water source has been disconnected
- I have received a notification that my water is going to be disconnected
- My water utility bill is delinquent or past due
- I need a deposit to turn the water on
- None of the above currently applies to my household
- Others (describe below)

12 If your cost of water/ wastewater services is included in your rent, give name and telephone number of your landlord. Attach a copy of a letter from the landlord confirming that your rent includes utilities.

Landlord Information:	Landlord Telephone Number:
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13 Please Provide the requested information for the utility providers from which you are seeking assistance with.

Drinking Water & Wastewater (sewer) Utility Company's Name:	Drinking Water & Wastewater (sewer) Customer's Name on Account:	Drinking Water & Wastewater (sewer) Customer's Account Number:	Drinking Water & Wastewater (sewer) Company's Telephone Number:	Drinking Water & Wastewater (sewer) Disconnection Date	Drinking Water & Wastewater (sewer) Payment Due Date:
Drinking Water Only Utility Company's Name:	Drinking Water Only Customer's Name on Account:	Drinking Water Only Customer's Account Number:	Drinking Water Only Company's Telephone Number:	Drinking Water Only Disconnection Date	Drinking Water Only Payment Due Date:
Wastewater (sewer) only Utility Company's Name:	Wastewater (sewer) On y Customer's Name on Account:	Wastewater (sewer) Only Customer's Account Number:	Wastewater (sewer) Only Company's Telephone Number:	Wastewater (sewer) Only Disconnection Date	Wastewater (sewer) Only Payment Due Date:
Landlord Utility Company's Name:	Landlord Utility Customer's Name on Account:	Landlord Utility Customer's Account Number:	Landlord Utility Company's Telephone Number:	Landlord Utility Disconnection Date	Landlord Utility Payment Due Date
Others - Utility Company's Name:	Others - Customer's Name on Account:	Others - Customer's Account Number:	Others - Company's Telephone Number:	Others - Disconnection Date	Others - Payment Due Date
Fines & Fees <small>(Amount of fines or fees listed on utility bill or invoice due to non- payment of late payment)</small>	\$				
Arrearage <small>(Amount of unpaid past due. Do not include fines or fees)</small>	\$				
Current Amount Due <small>(Amount of current charges due, do not include any past due amount, fines or fees)</small>	\$				

SUPPORTING DOCUMENTATION: Please select the type of Documentation from the options below and attach a copy

- Current Water Utility Statement*
- Current Pay Stub or Proof of Income
- Current State Issued ID*
- Current wastewater(sewer) Utility Bill (if separates from water)
- Copy of Lease agreement (if Utility paid to property Management/Landlord)
- Others

FRAUD STATEMENT: The information contained within this application is true, accurate and complete. I understand that by knowingly submitting inaccurate or false information I may be held liable to criminal prosecution. I also acknowledge that priority in providing assistance will be given to those households with the lowest income and greatest need, i.e., those households in which the elderly, disabled, medical needy or children reside. If approved I authorize the agency to make benefit payments directly to my Utility account. I am also aware that if I am not approved or denied within the time allowed, or not approved for the correct amount, I have a right to request an appeal or reconsideration.

APPEAL PROCESS:

Applicants have the right to appeal the decisions of the Administrating Agency.

1. An appeal must be submitted in writing within fifteen (15) calendar days of the completion of work or receipt of a decision in writing. An explanation should be provided detailing the nature of the specific complaint, or the problem with the work performed and why you believe it is not satisfactory. The appeal should be mailed to the attention of the community Subrecipient Agency LIHWAP Director.
2. The Subrecipient Agency LIHWAP Director will review your appeal and provide a written response via certified mail within fifteen (15) calendar days.
3. If you disagree with the above response, you may appeal to the Chief Operations Officer (COO) in writing by mailing an appeal to the COO of the Subrecipient agency within fifteen (15) calendar days of receiving the Director's response.
4. The COO will review your appeal and provide a written response via certified mail within fifteen (15) calendar days. If you disagree with the COO's response, you may appeal to the Chief Executive Officer (CEO) in writing by mailing an appeal to the CEO of the Subrecipient agency within fifteen (15) calendar days of receiving the COO's response.
5. The CEO will review your appeal and provide a written response via certified mail within fifteen (15) calendar days.
6. If you do not accept the CEO's response, you may appeal to the Board of Directors (Board) in writing within fifteen (15) calendar days of receiving the CEO's response.
7. The Board will review your appeal and provide written response via certified mail. The decision of the Board is the outcome of the appeal.

RECONSIDERATION:

A. Reconsideration means to re-evaluate eligibility, ineligibility, or the payment amount based on information that was unavailable or used incorrectly when the Agency decided eligibility.

B. DEO suggests a supervisory review when:

1. An Applicant received a denial notice; and,
 - (a) The Applicant requested reconsideration within the required timeframe stated in the Notice of Denial and Appeals.
 - (b) The Applicant requested reconsideration while funds remained.
2. An Applicant who is denied due to failure to provide requested information or verification submits the required information and funds remain.
3. An Applicant, who is denied, complains about the decision. In reviewing the case, staff finds the complaint has merit.
4. An Applicant, who is approved, complains about the amount of the benefit and the Agency finds that the payment was calculated incorrectly.
5. During case monitoring, it is found that the original decision (approval or denial) was possibly incorrect.

LIHWAP APPLICATION SUBMISSION:

Once you have completed your LIHWAP application by including all required supporting documentation, you may submit your application to the local LIHWAP provider for your Florida county based on the listing located at the web address provided below:

<https://www.floridajobs.org/community-planning-and-development/community-services/low-income-household-water-assistance-program/find-your-local-low-income-household-water-assistance-program-provider-for-help>

You may also submit your LIHWAP application and supporting documents to the Florida Department of Commerce (FloridaCommerce) by submitting them to the address, email or fax number provided below. Once received, a FloridaCommerce case manager will review and follow up, if necessary, to complete and submit your LIHWAP application to the local LIHWAP provider on your behalf.

LIHWAP PROGRAM
DEPARTMENT OF COMMERCE
BUREAU OF ECONOMIC SELF-SUFFICIENCY
107 EAST MADISON ST., 3rd FLOOR,
TALLAHASSEE, FLORIDA 32399-4128
FAX- (850) 208-6801
LIHWAP@COMMERCE.FL.GOV

FAIR HEARINGS:

The LIHWAP is subject to current Fair Hearing processes as required.

NOTICE OF ADMINISTRATIVE RIGHTS:

ANY PARTY WHOSE SUBSTANTIAL INTERESTS ARE AFFECTED BY THE BOARD'S FINAL DETERMINATION MAY INITIATE AN ADMINISTRATIVE PROCEEDING PURSUANT TO SECTION 120.569, FLORIDA STATUTES, BY FILING A PETITION.

A PETITION MUST BE FILED WITH THE AGENCY CLERK OF THE DEPARTMENT OF ECONOMIC OPPORTUNITY WITHIN 21 CALENDAR DAYS OF RECEIPT OF THE BOARD'S DETERMINATION. A PETITION IS FILED WHEN IT IS RECEIVED BY:

AGENCY CLERK
DEPARTMENT OF COMMERCE
OFFICE OF THE GENERAL COUNSEL
107 EAST MADISON ST., MSC 110
TALLAHASSEE, FLORIDA 32399-4128
FAX- 850-921-3230
AGENCY.CLERK@COMMERCE.FL.GOV

YOU WAIVE THE RIGHT TO AN ADMINISTRATIVE PROCEEDING IF YOU DO NOT FILE A PETITION WITH THE AGENCY CLERK WITHIN 21 CALENDAR DAYS OF RECEIPT OF THE BOARD'S DETERMINATION.

FOR THE REQUIRED CONTENTS OF A PETITION CHALLENGING AGENCY ACTION, REFER TO RULES 28-106.202(2), AND 28-106.301, FLORIDA ADMINISTRATIVE CODE.

DEPENDING ON WHETHER OR NOT MATERIAL FACTS ARE DISPUTED IN THE PETITION, A HEARING WILL BE CONDUCTED PURSUANT TO EITHER SECTIONS 120.569 AND 120.57(1), FLORIDA STATUTES, OR SECTIONS 120.569 AND 120.57(2), FLORIDA STATUTES.

PURSUANT TO SECTION 120.573, FLORIDA STATUTES, AND CHAPTER 28, PART IV, FLORIDA ADMINISTRATIVE CODE, YOU ARE NOTIFIED THAT MEDIATION IS NOT AVAILABLE.

NOTICE REGARDING COLLECTION OF SOCIAL SECURITY NUMBERS

The following disclosure is being made pursuant to section 119.071(5), Florida Statutes.

Social security numbers of applicants and household members are requested because this information has been determined to be imperative for the performance of the duties and responsibilities prescribed by law under the Low Income Household Water Assistance Program. This information is not required by state or federal law; however, social security numbers are necessary to determine eligibility for program services and specifically for the following purposes:

1. To verify an applicant's identity.
2. To verify household size.
3. To verify household income.

A social security number collected pursuant to this notice can only be used by the Florida Department of Economic Opportunity for the purposes specified above.

NONDISCLOSURE EXPECT UNDER LIMITED CIRCUMSTANCES:

Social security numbers will not be disclosed to others unless required or authorized by Florida law. Section 119.071(5), Florida Statutes, allows disclosure of a person's social security number under the following specific, limited circumstances:

- If disclosure is expressly required by federal or Florida law or is necessary for the agency or governmental entity to perform its duties and Responsibilities
- If the individual expressly consents to disclosure in writing.
- If disclosure is made to prevent and combat terrorism pursuant to the U.S. Patriot Act of 2001 or Presidential Executive Order 13224 (blocking property and prohibiting business transactions with persons who commit, threaten to commit, or support terrorism)
- For an agency employee and dependents, if disclosure is necessary to administer the person's health benefits or pension plan funds; or
- If disclosure is for the purpose of the administration of the Uniform Commercial Code by the office of the Secretary of State.
- If disclosure is requested by a commercial entity for permissible uses under the federal Driver's Privacy Protection Act of 1994, the federal Fair Credit Reporting Act, or the federal Financial Services Modernization Act of 1999 (for example, to verify the accuracy of personal information provided by the individual to the commercial entity; use by an insurer in connection with claims investigation or anti-fraud activities; for use in connection with a credit transaction).

ACKNOWLEDGMENT OF RECEIPT OF NOTICE:

- By checking this box, I confirm that I have been provided a copy of this Notice regarding the collection of my social security number and the social security numbers of all household occupants as part of the application process for the Florida LOW INCOME HOUSEHOLD ASSISTANCE PROGRAM.
- By checking this box, I hereby authorize the utility service company as provided in the application to disclose pertinent information regarding my account to agencies that may provide me financial assistance, including the Florida LIHWAP office. I understand and acknowledge the purpose of this disclosure is solely for federal reporting purposes and does not determine my eligibility for assistance. I further acknowledge and understand that the utility company provided within this application may be conserved confidential. I also understand and acknowledge that the named utility does not and will not have control over my account information provided to agencies pursuant to this acknowledgement and authorization. I will hold the utility company harmless for any claim related to the account information provided. This agency may verify information contained in the payment assistance application, including the utility account for which I am seeking assistance.
- By checking this box, I certify that all information entered by me in this application, as well as any attachments or supplemental information provided, are true and accurate to the best of my knowledge.
- By providing my signature or typed name below, I acknowledge and confirm that a typed name constitutes a legally-binding signature. I also confirm that I have been provided a copy of this Notice regarding collection of my Social Security Number and the Social Security Numbers of all household occupants as part of the application process for the Florida Low-Income Household Water Assistance Program.

APPLICANT SIGNATURE :	DATE :
CASEWORKER :	DATE :
SUPERVISOR/EDIT STAFF:	DATE :

Citizenship Documentation Affidavit

This form is for the collection of U.S. Citizenship/Nationality documents from applicants applying for benefits with a subrecipient agency funded by a federally funded public program. This form should be completed in the presence of a notary. **This form and copies of any required documents must be provided to the subrecipient agency's office.**

Applicants Name: _____ **Last 4 of SSN:** _____

I certify that I, _____ am the individual signing this statement
Print full name

I am providing a copy of my documents to prove my citizenship. I certify that the attached documents are the true, exact and complete copies of the originals issued to me.

Please check the Citizenship and/or immigration documents that are being attached:

- ___ Permanent Resident Card
- ___ Alien Registration Card
- ___ Certification of Naturalization OR Certificate of Citizenship
- ___ Passport
- ___ Other (i.e. parolee, asylee, or refugee documentation)

I understand that providing false or misleading information or documents is punishable by fine or imprisonment and may make me liable for repayment of any funds received on the basis of the information and documents I provided.

Student Signature

Date

Notary's Certification of Acknowledgment

State of _____ City/County of _____

On _____, before me, _____,
(Date) (Notary's name)

personally appeared, _____, and provided to me
(Printed name of signer)

on basis of satisfactory evidence of identification _____
(Type of government-issued photo ID provided)
to be the above-named person who signed the foregoing instrument.

WITNESS my hand and official seal
(seal)

(Notary signature)
My commission expires on _____
(Date)

EXHIBIT 3

Notice of Collection of Social Security Numbers

The following disclosure is being made pursuant to section 119.071(5), Florida Statutes.

Social security numbers of applicants and household members are requested because this information is crucial for the performance of the duties and responsibilities prescribed by law under the Low-Income Household Water Assistance Program. This information is not required by state or federal law; however, social security numbers are necessary to determine eligibility for program services and specifically for the following purposes:

1. To verify an applicant's identity
2. To verify household size
3. To verify household income

A social security number collected pursuant to this notice, can only be used by the Florida Department of Economic Opportunity and _____ for the purposes specified above.

Nondisclosure except under limited circumstances.

Social security numbers will not be disclosed to other entities unless required or authorized by Florida law. Section 119.071(5), Florida Statutes, allows disclosure of a person's social security number under the following specific, limited circumstances:

- If disclosure is expressly required by Federal or Florida law or is necessary for the subrecipient or governmental entity to perform its duties and responsibilities
- If the individual expressly consents to disclosure in writing
- If disclosure is made to prevent and combat terrorism pursuant to the U.S. Patriot Act of 2001 or Presidential Executive Order 13224 (blocking property and prohibiting business transactions with persons who commit, threaten to commit, or support terrorism)
- (For a subrecipient employee and dependents), if disclosure is necessary to administer the person's health benefits or pension plan funds, or
- If disclosure is for the purpose of the administration of the Uniform Commercial Code by the office of the Secretary of State
- If disclosure is requested by a commercial entity for permissible uses under the federal Driver's Privacy Protection Act of 1994, the federal Fair Credit Reporting Act, or the federal Financial Services Modernization Act of 1999 (for example, to verify the accuracy of personal information provided by the individual to the commercial entity; use by an insurer in connection with claims investigation or anti-fraud activities; for use in connection with a credit transaction).

Acknowledgment of Receipt of Notice

By checking this box, I acknowledge and confirm that by providing my signature or typed name below that a typed name constitutes a legally-binding signature.

By signing, I expressly authorize disclosure and confirm that I have been provided a copy of this Notice regarding collection of my Social Security Number and the Social Security Numbers of all household occupants as part of the application process for the Florida Low-Income Household Water Assistance Program.

Signature of Applicant

Signature of Subrecipient Staff

EXHIBIT 4

LIHWAP Performance Measures Data Collection Worksheet

PART 1 - CLIENT INFORMATION

Complete the following information based on the Applicant's LIHWAP Application

Applicant Name	
Customer of Record (if not Applicant)	
Vendor (Water)	
Account Number	
Vendor (Wastewater)	
Account Number	

PART 3 - IMMINENT RISK

YES	NO	QUESTION
		Was the applicant considered to be at imminent risk of losing needed home water source, and disruption was halted as a result of the applicant receiving a LIHWAP benefit (alone or in combination with another program)? <ul style="list-style-type: none"> • If Yes, count the Applicant as having home water disruption halted as a result of LIHWAP assistance • If No, do NOT count the applicant as having home water disruption halted as a result of LIHWAP assistance, however, the applicant may still be eligible for services

Some additional questions to consider if assistance is needed in determining if the Applicant should be counted in this category

YES	NO	QUESTION
		Does the applicant have a shut-off notice? This does not include a late bill or late notice.
		Does the applicant have less than 7 days of pre-paid water usage?

PART 4 – RESTORATION

YES	NO	QUESTION
		Was the home water source restored as a result of the applicant receiving a LIHWAP benefit (alone or in combination with another program)? <ul style="list-style-type: none"> • If Yes, count the applicant as having home water restored as a result of LIHWAP assistance • If No, do NOT count the applicant as having home water restored as a result of LIHWAP assistance, however, the Applicant may still be eligible for services

Some additional questions to consider if assistance is needed in determining if the Applicant should be counted in this category

YES	NO	QUESTION
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		Is the applicant currently without any water source, i.e., the utility has been disconnected or the tank is empty?
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PART 5 - WAIVER

YES	NO	QUESTION
		<p>Did the applicant sign the Authorization for Release of General and/or Confidential Information?</p> <ul style="list-style-type: none"> • If Yes, maintain a copy of the Release in the client file. • If No, make sure to note; however, the Applicant CANNOT be denied services because of refusal to sign the waiver.



LIHWAP Authorization for Release of Information Form

Authorization for Release of General and/or Confidential Information
For LIHWAP Federal Reporting

The Florida Department of Commerce’s (FloridaCommerce) Low-Income Household Water Assistance Program (LIHWAP) Program Office is requesting that you authorize your utility service provider to disclose the following information to the LIHWAP office to which you are applying for assistance:

- Your utility account status and history, such as payment history, past due amounts, deposits, current shut-off due dates or disconnection, current life support status, payment arrangements, and history of water assistance payments.
- Your total annual water usage and charges for up to twelve months.

The Florida LIHWAP office and its contractors will use this information to develop LIHWAP program performance measures and meet Federal reporting requirements.

Please note that:

- You have a right to receive a copy of this form.
- You are not required to authorize your utility service provider to disclose your customer data.
- Your decision not to authorize the disclosure will not affect your utility services or any LIHWAP assistance you may be eligible for.
- Your utility service provider may not disclose your customer data unless you authorize the disclosure to the LIHWAP office, FloridaCommerce, or as otherwise permitted or required by laws or regulations.
- Your utility service provider will have no control over the data disclosed pursuant to this consent, and will not be responsible for monitoring or taking any steps to ensure that the Florida LIHWAP office maintains the confidentiality of the data or uses the data as authorized by you.
- The Florida LIHWAP office will not disclose any private applicant information except for the purpose of administering public assistance as defined by State and Federal laws and regulations and developing LIHWAP program performance measures.

ACCOUNT HOLDER (CUSTOMER NAME):	
SERVICE ADDRESS FOR UTILITY:	
NAME OF UTILITY SERVICE PROVIDER:	
UTILITY ACCOUNT NUMBER:	
PHONE NUMBER FOR UTILITY ACCOUNT:	

SECTION A: APPLICANT READS AND COMPLETES THIS SECTION ONLY IF HE/SHE IS THE ACCOUNTHOLDER
I hereby authorize the above named utility and this agency to disclose pertinent information regarding my account to agencies that may provide me financial assistance, including the Florida LIHWAP Office. I understand that the purpose of this disclosure is solely for federal reporting purposes and

does not determine my eligibility for assistance. I further understand that some of the information the above named utility may provide to this agency may be considered confidential. I also understand that the above named utility does not and will not have control over any account information provided to agencies pursuant to this Authorization, and I will hold the utility harmless for any claim related to the account information provided. All information is accurate to the best of my knowledge. The agency may verify information contained in the payment assistance application, including the utility account for which I am seeking assistance.

ACCOUNT HOLDER'S SIGNATURE: _____ **DATE:** _____

SECTION B: APPLICANT READS AND COMPLETES THIS SECTION ONLY IF HE/SHE IS NOT THE ACCOUNT HOLDER

As applicant for payment assistance for the above named utility account, I hereby confirm, under penalty of perjury, that I am an Authorized Representative on behalf of the Account Holder and I have authority to initiate this assistance application on his/her behalf. This may be confirmed at the agency's discretion, by contacting the Account Holder. I, and the Account Holder, understand that the purpose of this disclosure is solely for federal reporting purposes and does not determine my eligibility. I further understand that some of the information the above named utility may provide to this agency may be considered confidential. I also understand that the above named utility does not and will not have control over any account information provided to agencies pursuant to this Authorization, and I will hold the utility harmless for any claim related to the account information provided. All information is accurate to the best of my knowledge. The agency may verify information contained in the payment assistance application, including the utility account for which I am seeking assistance.

APPLICANT'S NAME (NOT ACCOUNT HOLDER): _____

APPLICANT'S PHONE NUMBER: _____

APPLICANT'S SIGNATURE: _____ **DATE:** _____

SECTION C: FOR AGENCY USE ONLY

Agency must maintain this form in the Applicant's file and make it available to the utility vendor of record upon request, for accounting and auditing purposes.

AGENCY NAME: _____

PHONE: _____

AGENCY CASEWORKER'S NAME: _____

AGENCY CASEWORKER'S SIGNATURE: _____ **DATE:** _____