

ENERGY ASSISTANCE PROGRAM UTILITY AFFIDAVIT

Complete ONLY if your Utility Bills are in the name of someone who does not reside in the household

Head of Household's Name: _____ Date: _____						
Address: _____ City/State/Zip: _____						
Utility in non-household member's name (Check all that apply): <input type="checkbox"/> Electric <input type="checkbox"/> Heating						
Name and <u>current</u> address of person listed on utility bill(s): Name: _____ Address: _____ City/State/Zip: _____						
Relationship of the individual on the above-indicated utility bill(s) to the household member (check one): <table style="width: 100%; border: none;"><tr><td style="width: 50%;"><input type="checkbox"/> Spouse or significant other</td><td style="width: 50%;"><input type="checkbox"/> Landlord</td></tr><tr><td><input type="checkbox"/> Parent</td><td><input type="checkbox"/> Deceased family member</td></tr><tr><td><input type="checkbox"/> Child</td><td><input type="checkbox"/> Other: _____</td></tr></table>	<input type="checkbox"/> Spouse or significant other	<input type="checkbox"/> Landlord	<input type="checkbox"/> Parent	<input type="checkbox"/> Deceased family member	<input type="checkbox"/> Child	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Spouse or significant other	<input type="checkbox"/> Landlord					
<input type="checkbox"/> Parent	<input type="checkbox"/> Deceased family member					
<input type="checkbox"/> Child	<input type="checkbox"/> Other: _____					
Please explain barriers to placing the above utility/utilities in the name of a current household member: _____ _____ _____						
Certification Statement						
I hereby certify that the person (or persons) listed on the utility (or utilities) listed above is not a resident of this household and is not making financial contributions toward the overall household income. I also certify that I have received consent from the above-named account holder to release or allow to be released utility data and information for the purposes of eligibility determination and reporting. I understand that falsifying this information may result in disqualifying my household for IHCD-administered assistance program benefits or require my household to reimburse the agency for any benefits paid on behalf of this household.						
Signature of Head of Household: _____ Date: _____						