



CT BLOCK GRANT RECOVERY PROGRAM Client Application for Utility Supports



APPLICANT'S NAME: _____ **DATE:** _____

Social Security#: _____ - _____ - _____ **D.O.B:** ____ / ____ / ____

Have you experienced a sudden and significant loss of Income? Yes No

Gender: Male Female **Ethnicity:** Hispanic Non-Hispanic Unknown

Race: White Black/African American Asian/Pacific Islander
 American Indian/Alaskan Native Mixed or Other Race Unknown

Marital Status: Never Married Married/Cohabiting Separated Divorced
 Annulled Widowed Other Unknown

Total household gross monthly income (attach verification): _____

Total household monthly expenses: _____

Person making referral: _____ Title: _____

Agency: _____ LOC: _____

Phone#: _____ Email: _____

To be eligible for utility services, applicant must provide verification of termination of Utility Services.

Utility: _____ Amount Requested: \$ _____

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Utility: _____ Amount Requested: \$ _____

Applicant Attestation	
I understand that I am attesting to the following:	
<ul style="list-style-type: none"> The information provided is subject to verification and audit, and intentional misrepresentation may lead to criminal prosecution. 	
Signature of participant	Date
<i>(Original participant signature is required. Electronic signatures are not accepted)</i>	
Additional Required Documentation:	
<input type="checkbox"/> Utility bill in applicant's name OR <input type="checkbox"/> Termination of utility notification	
Completed form must be faxed to ABH at 860-967-0539	