WEATHERIZATION ASSISTANCE PROGRAMS

CLIENT INTAKE FORM

AGENCY NAME:		**JOB NO:**
CLIENT NAME:	OWNER'S NAME:	
SOCIAL SECURITY #: (last 4 digits)	PHONE NO.:	
UNIT ADDRESS:	MAILING ADDRESS:	
CITY: ZIP	COUNTY: ZIP	
LANDLORD AGREEMENT YES _____ NO _____	OWNERSHIP PROOF (source)	YEAR BUILT:

INCOME ELIGIBILITY: Must include annual income for **ALL** household members.

Type of Income:	**Client**	**Others in household**
A. EMPLOYMENT		
B. UNEMPLOYMENT COMPENSATION		
C. SOCIAL SECURITY		
D. SUPPLEMENTAL INCOME (SSI)		
E. RETIREMENT		
F. T.A.N.F.		
G. OTHER (type)		
Subtotals:		
TOTAL HOUSEHOLD INCOME = $		

Main Heating Fuel Source (Check one) Propane _____ Natural Gas _____ Electric _____ Wood _____ Other _____

TOTAL # OF PEOPLE RESIDING IN HOUSE:	
Utility Bill at time of application $	
CHARACTERISTICS OF All PEOPLE IN HOUSE: (Each person may be counted in more than one category)	
ELDERLY **(60& older)**	
DISABLED	
NATIVE AMERICAN INDIAN	
CHILDREN **(2 & under)**	
CHILDREN **(3 to 5 years)**	
CHILDREN **(6to 12 years)**	
All others not included in above categories	
Do any occupants have breathing or health issues? No Yes Issue:	

CLIENT CHARACTERISTICS:

Check each characteristic of the client who qualifies for assistance.
(Client may be counted in more than one category. Client is not a child.)

ELDERLY **(60 & older)**	
DISABLED	
N. AMERICAN INDIAN	
HIGH ENERGY BURDEN HOUSEHOLD	
RECURRING HIGH ENERGY BURDEN (LIHEAP Referral)	
OTHER (Income qualified only)	
UNITS BY OCCUPANCY: check only one below:	
OWNER OCCUPIED HOME	
SINGLE FAMILY RENTER	
MULTI FAMILY	
OWNER MOBILE HOME	
RENTER MOBILE HOME	

CLIENT AGREEMENT:

1. I voluntarily waive the provisions of the Privacy Act in order to permit verification of my income eligibility.
2. I certify that my household meets the income guidelines of this program.
3. I hereby give permission to enter these premises for the purpose of conducting and energy audit and having my home weatherize.
4. I authorize this agency or its representatives to obtain information regarding my utility usage as needed from the appropriate utility company.
5. There are ____ are not ____ occupant health issues that will prevent perfroming diagnostic testing.

CLIENT SIGNATURE: **DATE:**

A COPY OF THIS CLIENT INTAKE FORM IS REQUIRED FOR EACH PROGRAM FROM WHICH FUNDS WERE UTILIZED ON THIS UNIT. **Form CIF-10**