

UTILITY ASSISTANCE APPLICATION

APPLICANT INFORMATION

First Name	Last Name	Email Address
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Date of Birth

MAILING ADDRESS INFORMATION

Street Address	Apartment/Unit #/Floor (if applicable)
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City	State	Zip Code	County
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SERVICE ADDRESS INFORMATION

Check here if the service address is the same as the mailing address above. If the same, do not fill below.

Street Address	Apartment/Unit #/Floor (if applicable)
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City	State	Zip Code	County
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DEMOGRAPHICS HEAD OF HOUSEHOLD INFORMATION

Is applicant the head of household? (This is the person responsible for the household bills) Yes No

Head of household marital status Married Single Separated/ Divorced Widow/Widower

Head of household age 18-49 50-59 60+

Is head of household a U.S. Veteran? Yes No

Head of household gender Male Female Other Decline to answer

Head of household race Alaska Native American Indian Asian Black or African American
 Mixed Race Native Hawaiian Other Pacific Islander White Decline to answer

Head of household ethnicity Hispanic or Latino Not Hispanic or Latino Other Decline to answer

Head of household other characteristics None Single Parent Grandparent with child
 Widow/Widower Other _____

DEMOGRAPHICS

APPLICANT INFORMATION (Fill out only if Applicant is not Head of Household)

- Marital status of applicant** Married Single Separated/ Divorced Widow/Widower
- Age of applicant** 18-49 50-59 60+
- Is applicant a U.S. Veteran?** Yes No
- Applicant gender** Male Female Other Decline to answer
- Applicant race** Alaska Native American Indian Asian Black or African American Mixed Race
 Native Hawaiian Other Pacific Islander White Decline to answer
- Applicant ethnicity** Hispanic or Latino Not Hispanic or Latino Other Decline to answer
- Applicant other characteristics** None Single Parent Grandparent with child Widow/Widower
 Other _____

RESIDENCE INFORMATION

- Applicant Age 65+ Applicant Receives Social Security Disability Rent Own
- Has anyone in the household applied for unemployment or temporary disability?** Yes No
- Does anyone in the household have a medical condition and relies on electric-powered medical equipment?** Yes No
- How long have you lived at current residence?** _____
- How is the residence heated?** Gas Electric Oil Propane Other _____
- Number of people who live in the household (by age)**
- 0-6 Years _____ 7-17 Years _____ 18-49 _____ 50-59 Years _____ 60+ Years _____

ASSISTANCE RECEIVED

(This section is NOT required if only applying for Veolia Cares Program)

- Has anyone in the household received assistance within the current benefit year.** Yes No
- If Yes, select all assistance received from the programs listed below.**
- Affordable Connectivity Program (ACP) AQUA Aid Program
- Low Income Home Energy Assistance Program (LIHEAP) Lifeline Communications Program
- Lifeline Utility Assistance Program NJ American Water H2O Program NJ FamilyCare/Medicaid
- NJ SHARES Energy Assistance Grant NJ SMART Program NJ SHARES SMART Utility Assistance Program
- Supplemental Security Income (SSI) Universal Service Fund (USF) Veterans Pension
- Veterans Survivors Pension WorkFirst NJ - Temporary Assistance for Needy Families (TANF)

INCOME INFORMATION

(This section is NOT required if only applying for Veolia Cares Program)

Total Adults (18+ years) in the household _____ **How many adults have income in the household** _____

Number of adults that do not have income _____ **(Complete form on last page for adults with no income.)**

Income Source Employment Pension Social Security with Medicare Social Security without Medicare
 Disability Unemployment Child Support Rental Income Other _____

Income for each adult household member (Adult #1)

Weekly – Amount 1: \$ _____ Amount 2: \$ _____ Amount 3: \$ _____ Amount 4: \$ _____

Every 2 Weeks – Amount 1: \$ _____ Amount 2: \$ _____ Amount 3: \$ _____

Twice a Month – Amount 1: \$ _____ Amount 2: \$ _____

Monthly – Amount 1: \$ _____

Income for each adult household member (Adult #2, if needed)

Weekly – Amount 1: \$ _____ Amount 2: \$ _____ Amount 3: \$ _____ Amount 4: \$ _____

Every 2 Weeks – Amount 1: \$ _____ Amount 2: \$ _____ Amount 3: \$ _____

Twice a Month – Amount 1: \$ _____ Amount 2: \$ _____

Monthly – Amount 1: \$ _____

If additional household members have income, please use page 5 of the application.

MISCELLANEOUS INFORMATION

Phone number _____ Cell Home **Phone number** _____ Cell Home

I agree to receive SMS text messages related to my application or other assistance I may be eligible to receive.











Why do you need help? Medical/Health Unemployed Reduced Hours/Change in employment
 Other _____

Primary language (if other than English) _____

How did you hear about SHARES? Referral from Utility Company Community Organization Friend
 Elected Official SHARES Outreach Other _____

UTILITY INFORMATION

What type of assistance are you applying for? Select all that apply

ENERGY				WATER			
<input type="checkbox"/> 	<input type="checkbox"/> 	<input type="checkbox"/> 	<input type="checkbox"/>	<input type="checkbox"/> 	<input type="checkbox"/>	<input type="checkbox"/> 	<input type="checkbox"/> 
<input type="checkbox"/> 	<input type="checkbox"/> 	<input type="checkbox"/> 	<input type="checkbox"/>				
<input type="checkbox"/> 	<input type="checkbox"/> Municipal Electric Utility _____			<input type="checkbox"/>	<input type="checkbox"/> Municipal Water Utility _____		
				<input type="checkbox"/>	<input type="checkbox"/> Municipal Sewer Utility _____		

If you are approved for the [New Jersey American Water Universal Affordability Discount Program](#), would you be interested in signing up to receive a water conservation kit? Yes No

Utility account holder name and utility account number	Utility account holder name and utility account number	Utility account holder name and utility account number	Utility account holder name and utility account number
Utility bill balance	Utility bill balance	Utility bill balance	Utility bill balance
Date & amount of last payment	Date & amount of last payment	Date & amount of last payment	Date & amount of last payment
Shut off date (if applicable)	Shut off date (if applicable)	Shut off date (if applicable)	Shut off date (if applicable)

If Atlantic City Electric was selected, please answer the below questions:

1. Have you had an assessment by Atlantic City Electric to have your meter replaced? Yes No
2. If yes, do you have an invitation code? Yes No If yes, enter code here: _____

If Jersey Central Power & Light was selected, please answer the below questions:

1. Have you had an assessment by FirstEnergy to have your meter replaced? Yes No
2. If yes, do you have an invitation code? Yes No If yes, enter code here: _____

**SUBMISSION OF AN APPLICATION DOES NOT GUARANTEE ASSISTANCE.
 EVEN IF ASSISTANCE IS PROVIDED IT IS VERY IMPORTANT YOU KEEP MAKING PAYMENTS.**

VERIFICATION OF INFORMATION/PRIVACY RELEASE

*The personal information you provide when applying for an assistance program with SHARES is used to facilitate an assistance application. Submitting your information indicates that you have read and agree to the following:
 By signing, I certify that the information given in and attached to this application is true, complete, and correct. I am aware and understand that if any information contained in or attached to this application is willfully false, that I am subject to criminal prosecution. I understand that I must provide the required documentation and any additional requested documentation within 10 business days in order to proceed with the application process. I hereby authorize my utility provider(s) to release my customer account information, including usage, payment history, and participation in other utility grant programs to SHARES for the purpose of processing my SHARES application and monitoring the progress of my utility account(s). I understand that the information in this application may be shared to ensure access to all assistance programs for which I may be eligible. This authorization shall expire one year from the date the SHARES application is signed.*

Applicant Signature	Date
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FOR AGENCY USE ONLY

Date	Agent/Representative Name	Agency Name & Location

(Additional Income, if applicable)

Income for each adult household member (Adult #3, if needed)

- Weekly – Amount 1: \$_____ Amount 2: \$_____ Amount 3: \$_____ Amount 4: \$_____
- Every 2 Weeks – Amount 1: \$_____ Amount 2: \$_____ Amount 3: \$_____
- Twice a Month – Amount 1: \$_____ Amount 2: \$_____
- Monthly – Amount 1: \$_____

Income for each adult household member (Adult #4, if needed)

- Weekly – Amount 1: \$_____ Amount 2: \$_____ Amount 3: \$_____ Amount 4: \$_____
- Every 2 Weeks – Amount 1: \$_____ Amount 2: \$_____ Amount 3: \$_____
- Twice a Month – Amount 1: \$_____ Amount 2: \$_____
- Monthly – Amount 1: \$_____

Income for each adult household member (Adult #5, if needed)

- Weekly – Amount 1: \$_____ Amount 2: \$_____ Amount 3: \$_____ Amount 4: \$_____
- Every 2 Weeks – Amount 1: \$_____ Amount 2: \$_____ Amount 3: \$_____
- Twice a Month – Amount 1: \$_____ Amount 2: \$_____
- Monthly – Amount 1: \$_____

Zero Income Affirmation

This page is to be completed and signed by the applicant when there are adult household members without income. This is not required if only applying for Veolia Cares Program.

I affirm that the following adult household members have zero income and do not contribute to my household expenses:

Print First Name	Print Last Name

Print First Name	Print Last Name

Print First Name	Print Last Name

Print First Name	Print Last Name

Print First Name	Print Last Name

Applicant Signature: _____

Date: _____