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: ____ Level of Care (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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Applicant Attestation

I understand that I am attesting to the following:

- The information provided is subject to verification and audit, and intentional misrepresentation may lead to criminal prosecution.

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Signature of participant **Date**
(Original participant signature is required. Electronic signatures are not accepted.)

Additional Required Documentation:

☐ Utility bill in applicant's name OR
☐ Termination of utility notification

Completed form must be faxed to ABH at 860-967-0539