

ENERGY ASSISTANCE PROGRAM (EAP) LANDLORD AFFIDAVIT

Landlord: Please complete this affidavit on behalf of your resident who is applying to receive benefits to assist with his/her utility costs. The information provided is confidential and will not be shared with any other organization or government agency. Complete in blue or black ink only.

APPLICANT INFORMATION (may be completed by applicant, intake, or landlord)

Applicant Name:	Date:
Address:	Phone:
City:	State: IN Zip Code:

DWELLING AND UTILITY INFORMATION – to be completed by the landlord, property owner, leasing agent, or authorized designee only. All fields are required.

Heating costs are (check one):	Electric costs are (check one):
<input type="checkbox"/> Responsibility of the landlord, included in the tenant's monthly rent payment.	<input type="checkbox"/> Responsibility of the landlord, included in the tenant's monthly rent payment.
<input type="checkbox"/> Responsibility of the tenant, but in the landlord's name	<input type="checkbox"/> Responsibility of the tenant, but in the landlord's name
<input type="checkbox"/> Responsibility of the tenant	<input type="checkbox"/> Responsibility of the tenant

Primary heating source (check one):

- Electric (furnace, baseboard, or wall unit)
 Natural gas
 LP gas, fuel oil, wood, coal, pellets, kerosene

How much is the tenant responsible to pay out of pocket each month in rent? \$ _____

Is the primary heating source operable?
 Yes No

All contact information is required unless otherwise noted.

<i>I grant IHEDA permission to obtain utility information on account status, energy cost and consumptions data on this property for the purpose of data consumption tracking.</i>	
Landlord or authorized designee name:	Landlord or authorized designee signature:
Address:	Date:
City:	Phone:
State: Zip Code:	Email (optional):

Direct Benefit Payment Election Form

Head of Household _____

Please choose a fulfillment option below for your direct benefit payment. **Please check one.**

- I would like to waive my direct benefit payment to be applied directly to my electricity/heating (**circle one**) utility, which I pay separately. I understand that the full benefit will be paid to my vendor within sixty (60) days and I will not receive a direct payment.
- I would like to receive my direct benefit payment as a check mailed to my primary residence or mailing address. **I understand that this may take up to 150 days to receive**, and is subject to further delays if I have provided an incorrect address, if I move, or due to USPS operations. **If you do not return this form with your application, your benefit will be issued as a check.**
- I would like to receive my direct benefit payment as an Electronic Funds Transfer (direct deposit). **I understand that this may take up to 120 days to receive**, and is subject to further delays if I have provided inaccurate banking information. I have provided my banking information below.

Checking Account Savings Account Name on account: _____

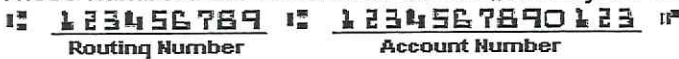
Financial Institution: _____

Financial Institution Routing Number: **(must be nine digits)**

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Checking/Savings Account Number: _____

These numbers are located on the bottom of your check as follows:



I hereby certify that the information provided above is correct and true. I understand that I may be required to verify these statements and hereby give my consent to the agency from which I am requesting assistance to make contact with any necessary persons to verify these statements. I understand that falsifying this information may result in disqualifying my household for Energy Assistance Program benefits or require my household to reimburse the agency for any benefits paid on behalf of this household based on any misrepresentation or omission.

If I have elected to receive benefit payment by electronic funds transfer, I hereby authorize the Indiana Housing and Community Development Authority ("IHCDA") to initiate entries to: _____'s checking/savings accounts at the financial institution listed above, and, if necessary, initiate adjustments for any transactions credited/debited in error. This authority will remain in effect until IHCDA is notified by an authorized individual in writing to cancel it in such time as to afford IHCDA and the financial institution a reasonable opportunity to act on it. In addition, I certify that I have full authority to execute this authorization and grant the rights to IHCDA contained herein.

Applicant Signature

Date