



Pueblo of Laguna Utility Authority

Payment Assistance Application - 2025 Funding Year

THIS APPLICATION MAY ONLY BE USED FOR THE PAYMENT ASSISTANCE PROGRAM

APPLICANT INFORMATION				
Name of Account Holder	Date of Birth	Age	Disabled	Tribal Member
1			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Physical Address	Village	Phone #	Message Phone #	Tribal Member #
Mailing Address	City	State	Zip Code	Utility Account #

HOUSEHOLD INFORMATION			
Household Members <small>(not including Applicant)</small>	Date of Birth	Age	Disabled? <small>Must include proof of disability</small>
2			<input type="checkbox"/> YES <input type="checkbox"/> NO
3			<input type="checkbox"/> YES <input type="checkbox"/> NO
4			<input type="checkbox"/> YES <input type="checkbox"/> NO
5			<input type="checkbox"/> YES <input type="checkbox"/> NO
6			<input type="checkbox"/> YES <input type="checkbox"/> NO
7			<input type="checkbox"/> YES <input type="checkbox"/> NO
8			<input type="checkbox"/> YES <input type="checkbox"/> NO

INCOME INFORMATION

Checkmark all sources of income for all household members and attach proof of the income for the last 30 days

- ☐ Employment

☐ Social Security

☐ Other _____

☐ Unemployment

☐ Disability Benefits

☐ Self Employment

☐ Retirement - All Types

Person with Income	Income Source	\$ Amount	How Often? <small>Weekly, Biweekly, Monthly, Semi-Monthly, Seasonal</small>



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INFORMATION AND CONSENTS: (PLEASE READ CAREFULLY BEFORE SIGNING)

I understand that by submitting this application all information is true, complete and correct. I understand that any false statements or other misrepresentation knowingly made by me in connection with this application for Payment Assistance Program benefits may result in me being found ineligible for the assistance paid on my behalf for my water, wastewater, septic, and/or solid waste provider.

I understand that by signing my Payment Assistance Program application and documents I have provided, will be used to check my identity and may be disclosed or re-disclosed to verify earned income and other assistance received for myself and other household members and to determine if applicants can receive payments or other assistance.

I give my consent for POLUA or other federal, local or other authorized personnel to record, store, access and utilize the information provided on this application and any documents that I have provided, as well as information provided in any conversations, texts, or other means of communication with POLUA or federal, local, or other authorized personnel.

I also consent to the release and use of information provided on this application or pertaining to my eligibility for Payment Assistance program to any other entity to avoid duplication of benefits. I understand that additional information may be requested by POLUA in connection with my application for Payment Assistance Program benefits, and I agree to provide such requested information within the time allotted by POLUA.

I have read and understand the consents above and agree that by signing and submitting this application to the POLUA that I do so under penalty or perjury, which may subject me to civil and/or criminal penalties.

Account Holder's Signature

Date

FOR UTILITY AUTHORITY USE ONLY

Date Rec'd:

Current Balance:

Is account in arrears?

☐ Yes ☐ No

Document Checklist:

☐ Social Security Disability Benefits

☐ Doctor Statement

☐ Earned Income statements

☐ No Income statement(s)

☐ Self employment statement(s)

☐ Retirement statement(s)

☐ Class schedule for students 18 & over

Rec'd By:

LHDME Unit?

If so, how much:

☐ Yes ☐ No

LIHWAP Benefits

Payback Agreement

☐ Yes ☐ No

☐ Yes ☐ No