

**THE ARC OF INDIANA MASTER TRUST  
2012 WINTER HEATING ASSISTANCE PROGRAM  
CERTIFICATION FORM**

By signing this Certification Form, you are agreeing that the following information is correct:

1. The person for whom this payment is being made is disabled.
2. The person for whom this payment is being made is a recipient of either:  
Supplemental Security Income (SSI) or Medicaid Disability.
3. This payment will not supplant other sources of income or resources that are routinely used to pay this person's monthly bills, and this payment supplements, not supplants, those other sources of income or resources.

**DOCUMENTATION THAT THE PERSON IS A RECIPIENT OF SSI OR MEDICAID DISABILITY *MUST* BE PROVIDED ALONG WITH THIS CERTIFICATION FORM IN ORDER FOR THE APPLICATION TO BE APPROVED.**

DATE: \_\_\_\_\_

Agency: \_\_\_\_\_

Agency Representative Name: \_\_\_\_\_

Agency Representative Signature: \_\_\_\_\_

Phone: (\_\_\_\_)\_\_\_\_\_ E-Mail: \_\_\_\_\_

Recipient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: Indiana Zip: \_\_\_\_\_

County: \_\_\_\_\_

Phone: (\_\_\_\_)\_\_\_\_\_

Utility Company: \_\_\_\_\_

Utility Account Number: \_\_\_\_\_

Utility Company Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: Indiana Zip: \_\_\_\_\_

**Please return form and SSI or Medicaid Disability Documentation to:  
The Arc of Indiana  
107 N. Pennsylvania Street, Suite 800  
Indianapolis, Indiana 46204**

**Or Fax to: 317-977-2385**

For more information, call 317-977-2375 or 1-800-382-9100