"First In Service"

APPLICATION FOR WINTER PROTECTION PLAN
LOW INCOME 2023-2024

Name _____ Social Security#_____

Address _____

Account # _____ Phone # _____ Cell Phone # _____

No. of Household Members: _____ Annual Household Income $ _____

Mark any that apply:

Family independence Program: _____ Home heating credit: _____

Child Development Care Program: _____ Food stamp recipient: _____

State Emergency Relief Program: _____ Medicaid Recipient: _____

State Disability Assistance Recipient: _____

I do hereby certify the information furnished by me to be correct and accurate. I understand that any misrepresentation of information may result in my removal from the program. I understand that within fourteen (14) business days of requesting shut off protection, I must furnish my utility company with proof of application for State of Federal heating assistance in order to qualify for the WINTER PROTECTION PROGRAM. I understand that the company, upon proper notice, may discontinue service if my; monthly payments are not made. By signing this I also give my permission to release information requested to Alpena Power Company.

Signed: _____ Date: _____

MDHHS Representative: _____Date: _____

WINTER PROTECTION PAYMENT FROM NOVEMBER 1, 2023 THROUGH MARCH 31, 2024:

7% of your Estimated **annual** bill plus a portion (depending on the number of months remaining in the winter protection program) of any arrearage.

7% of Estimated Annual Bill $ _____

Portion of Arrearage $ _____

Total amount to pay per month Dec 1, 2023 to Mar 31, 2024 $ _____

Your monthly amount will be reviewed on April 1, 2024. At that time, a new monthly amount may be calculated based on the deferred balance of your account. If at any time your deferred balance becomes zero or a credit, your monthly amount will be reviewed to determine if a new monthly amount should be calculated.

APC Representative: _____ Date:_____

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