MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Department of Public Health and Human Services

Human and Community Services Division Intergovernmental Human Services Bureau
PO Box 202956 Helena, MT 59620-2956

Greg Gianforte, Governor

Adam Meier, Director

DATE: July 19, 2021

TO: Public Water System Providers

FROM: Sara Loewen, DPHHS Intergovernmental Human Services Bureau Chief

SUBJECT: Low-Income Home Water Assistance Program (LIHWAP) Contractor Application and Contract

A temporary emergency Low-Income Home Water Assistance Program[1] (LIHWAP) is being developed to provide low-income households assistance in paying their water and wastewater bills. Funds will be sent directly to Public Water System (PWS) operators to be credited to income eligible household accounts to reduce arrearages, prevent shutoffs and reduce monthly rates. This program is slated to operate from October 1, 2021 through September 30, 2023. Households will apply for assistance through a process coordinated with the Low-Income Energy Assistance (LIEAP) program.

The MT Department of Public Health and Human Services is providing the opportunity to PWS providers to participate in this program through a contract with the Department in order to receive and provide this assistance to income eligible households. The Department is beginning the process of securing contracts with PWS providers interested in participating in the LIHWAP.

The following documents are enclosed:

1. A copy of the (DPHHS-HWAP-001) Low Income Home Water Assistance Program Contractor Application and Contract for the time period October 1, 2021 through September 30, 2023.
   Complete the Contractor Information sections, including the Contractor Taxpayer ID number field. Sign the bottom of page three. The contract will be signed by a Department representative and a copy will be returned for your records.

2. A Taxpayer Identification Number (TIN) Verification (W-9) form. The completed W-9 form is required to receive payments from the Department. The W-9 form will be used to verify the TIN and the address where the 1099 form will be sent.

[1] The LIHWAP program is authorized under Section 533 Title V of Division H of the Consolidated Appropriations act of 2021, Public Law No: 116-260 and as provided for under The American Rescue Plan Act (ARPA). Additional information can be found at: https://www.acf.hhs.gov/ocs/programs/lihwap.

3. A Payment Address Form to complete and return if the mailing address for the LIHWAP payment is to be made to an address other than the one entered on the W-9 form.

4. A Direct Deposit Sign-up Form to complete if your company would prefer to have payments made directly to your financial institution. A written Statement of Remittance (SOR) will be mailed as usual but LIHWAP funds will be available at least one day earlier.

In order to participate and receive funds under this program, items #1 and #2 (above) must be completed and returned, along with items #3 and #4 if applicable.

These documents should be mailed to:
DPHHS LIHWAP, PO Box 202925, Helena, MT 59620

We encourage all Public Water System providers to complete the above information in order to participate in the program and allow their customers to receive this assistance.

Look for additional information (coming soon) at www.lieap.mt.gov. A list of frequently asked questions will be available. You can also email Program Specialist Sheri Shepherd at sshepherd2@mt.gov.

Thank you for considering participating in the Low Income Home Water Assistance Program aimed at reducing arrearages and rates of low-income households, particularly those with the lowest incomes, that pay a high proportion of household income for drinking water and wastewater services.

Sara Loewen
Intergovernmental Human Services Bureau Chief
Human and Community Services Division, MT DPHHS

Montana Department of Public Health and Human Services
Human and Community Services Division, P.O. Box 202956, Helena, Montana 59620-2956

2021-2023
LOW INCOME HOME WATER/WASTEWATER ASSISTANCE PROGRAM
CONTRACTOR APPLICATION AND CONTRACT

Contractor Name:	
Mailing Address:	**Type(s) Service Supplied:** ❑ **Water and Wastewater** ❑ **Water Only** ❑ **Wastewater only**
City, State Zip:	**Contractor Taxpayer ID# (EIN or SSN)**
Email Address:	**Telephone #:**
Type of Entity: ❑ **Partnership (Must use EIN)** ❑ **Individual/Sole Proprietor (EIN or SSN)** ❑ **Corporation (Must use EIN)** ***A completed Form W-9 must be submitted with this contract.***	
Contractor Number Issued by DPHHS:	

THIS CONTRACT, is entered into by and between the MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES (hereinafter referred to as the "Department"), and the home Public Water or Wastewater supplier identified above, (hereinafter referred to as the "Contractor").

WITNESSETH THAT, in consideration of the mutual covenants and agreements herein contained, the parties agree as follows:

1. The purpose of this contract shall be to assist low income households (Eligible Customers) to offset the cost of water and/or wastewater services under the Low Income Home Water/Wastewater Assistance Program (LIHWAP) is authorized under Section 533 Title V of Division H of the Consolidated Appropriations Act, 2021, Public Law No: 116-260 and as provided for under the American Rescue Plan Act. ,

2. The effective date and duration of this contract shall be October 1, 2021 through September 30, 2023.

3. To receive direct payments from the Department under LIHWAP, the Contractor agrees:
   a. To provide appropriate and timely delivery of home water and/or wastewater services to Eligible Customers.
   b. To charge the Eligible Customers the difference between the actual cost of the home water and/or wastewater services and the amount of the payment made by the Department.
   c. Not to adversely discriminate in the cost, services or treatment provided to the Eligible Customer on whose behalf a LIHWAP payment is made.
   d. To provide to the Department upon request, with written reconciliation and confirmation that benefits have been credited appropriately to households and their services have been restored on a timely basis or disconnection status has been removed if applicable. The reconciliation must show amount applied to each eligible recipient account for arrearages, late fees, reconnection fees and/or regular monthly bill rate reduction.
   e. To clearly enter, on LIHWAP households' bill, the amount of LIHWAP payment(s) received in a manner which identifies the payment as received from LIHWAP.
   f. That any funds paid by the Department will be used only to meet an Eligible Customer's home water and/or wastewater service needs. Resale or transfer of funds paid to any other party is prohibited.
   g. Provide all cost and consumption data for LIHWAP recipients to the Department.

4. In consideration of the assurances given in Section 3 of this contract, the Department agrees each Federal Fiscal Year to:
   a. Determine which customers are eligible for LIHWAP.
   b. Pay the Contractor an amount determined by the Department LIHWAP policies in accordance with the approved LIHWAP State Plan.
   c. Upon receipt of LIHWAP eligibility notification, pay the Contractor on a schedule determined by the Department.

5. The Contractor agrees to:
    a. Credit the payment amount to the eligible customer's account when received and identified by the statement of remittance.
    b. Use the LIHWAP payment only to pay home water and/or wastewater service obligations the LIHWAP customer previously incurred or incurs during the period from October 1, 2021 through September 30, 2023. for which the payment was issued, Funds may be used to reduce arrearages and/or rates charged to the eligible household o provide continuity of water services, including prevention of disconnection and restoration of water services to households whose water services were previously disconnected.
    c. Return to the Department any LIHWAP-attributable credit balance no later than September 30, 2023 and include customer's name, LIHWAP benefit issuance date, and account number with the returned funds.
    d. Return to the Department within ninety (90) days from the date of discontinued service, which includes, but is not limited to, changes of address, account number, or death of recipient, any credit balance and/or line of credit in an eligible customer's account that is identifiable as LIHWAP funds. Include customer's name, LIHWAP benefit issuance date, and account number with remittance.
    e. Provide as requested, to facilitate State compliance with Federal reporting requirements, LIHWAP recipients' annual water and/or wastewater service consumption data and written reconciliation of LIHWAP funds applied to the recipient's account..
    f. The mailing address for returned funds is DPHHS/HCSD, P.O. BOX 202956, HELENA, MT 59620.
    g. LIHWAP funds may not be used for the purchase or improvement of land or the purchase, construction, or permanent improvement of any building or facility.
    h. Report any financial fraud, abuse or misconduct by recipients or in the administration of LIHWAP. If there are reasonable grounds to believe that fraud, abuse or misconduct has occurred call 406-447-4269 or email sshepherd2@mt.gov.
    i. Cooperate with all investigations of suspected fraud, abuse or misconduct.

6. The Contractor will comply with the Civil Rights Act of 1964. The Contractor agrees that no person shall, on the grounds of race, color, national origin, creed, sex, religion, political ideas, marital status, age or handicap be excluded from employment or participation in, be denied benefits, or be otherwise subject to discrimination under any program or activity connected with the implementation of this contract, and further agrees that affirmative steps will be taken to employ or advance in employment qualified handicapped individuals. The Contractor further agrees that all hiring done in connection with this contract shall be based on merit qualification genuinely related to competent performance of the occupational task.

7. The use or disclosure, by any party, of any information concerning a claimant in violation of any rule of confidentiality, or for any purpose not directly connected with the administration of the Department's or the Contractor's responsibility with respect to services hereunder, is prohibited, except on written consent of the claimant, or the court appointed guardian of a claimant.

8. The Contractor will comply with all applicable regulations and formal Department policies, including those pertaining to licensing, in performing this contract.

9. The Contractor agrees to submit all reports and documents required by this contract or by federal or state law or regulations, timely in the form required by the Department.

10. The Contractor agrees that it will, at all times, indemnify the Department and hold it harmless from any and all losses and claims that may result to the Department because of any negligence on the part of the Contractor, its agents, representatives or employees.

11. The Contractor agrees not to subcontract, assign or transfer any work contemplated under this contract without prior written approval of the Department.

12. The Contractor shall not be liable for failure to perform under this contract if such failure to perform arises out of causes beyond the control and without the fault or negligence on the part of the Contractor. Such causes may include, but are not restricted to, acts of God or the public enemy, fires, floods, epidemics, quarantine restrictions, freight embargoes, and unusually severe weather; but in every case the failure to perform must be beyond the control and without the fault or negligence of the Contractor.

13. The parties agree that if anticipated government funds are reduced or become unavailable any time during the term of the contract, the Department is not obligated to continue performance of this contract beyond the date the federal or state funds are reduced or become unavailable.

14. If the Contractor fails to provide services called for by this contract or to provide such services within the time specified herein, or any extension thereof, the Department may withhold payment or by written notice of default to the Contractor, terminate the whole or any part of the contract upon written notice. This contract may be canceled or terminated by either of the parties without

cause, however; the parties seeking to terminate or cancel this contract must give written notice of its intention to do so to the other party at least thirty (30) days prior to the effective day of cancellation or termination.

15. The State of Montana, the Department, the U.S. Department of Health and Human Services, and the Comptroller General of the U.S., or any of their duly authorized representatives, shall have the right of access to any books, documents, papers and records of the Contractor which are pertinent to the services provided under this contract, for purposes of making audit, excerpts or transcripts. Further, for purposes of verifying cost or pricing data submitted in conjunction with the negotiation of this contract or any amendments thereto, the State shall until the expiration of eight (8) years from the completion date of a program year, have the right to examine those books, records, documents, papers, and other supporting data which involve transactions related to this contract or which will permit adequate evaluation of the cost or pricing data submitted, along with the computations and projections used therein. The Contractor's accounting procedures and practices shall conform to generally accepted accounting principles.

16. Financial records, supporting documents, statistical records and all other records supporting the services provided by the Contractor under this contract shall be retained for a period of eight (8) years from the completion date of a program year. The Contractor agrees to make the records described herein available at all reasonable times at the Contractor's general offices. If any litigation, claim or audit is started before the expiration of the eight-year period, the records shall be retained until all litigations, claims or audit findings involving the records have been resolved.

17. The Contractor assures the Department that the Contractor is an independent contractor providing services for the Department and that neither the Contractor nor any of the Contractor's employees are employees of the Department under this contract, nor will be considered employees of the Department under any subsequent amendment to this contract unless otherwise expressed.

    The Contractor must obtain and maintain workers' compensation coverage for the Contractor and the Contractor's employees as provided in Montana law (39-71-401 and 39-71-405, MCA, and as they may be subsequently amended, modified or altered). The Contractor must provide the Department with proof of compliance with the relevant statutory provisions cited herein. The Contractor need not obtain workers' compensation coverage or an exemption therefrom, if the contract is one for casual employment as exempted at 39-71-401(2)(b), MCA.

18. The parties agree that in the event of litigation concerning this contract, venue shall be in the First Judicial District in and for the County of Lewis and Clark, State of Montana.

19. This instrument contains the entire contract between the parties and no statements, promises or inducements made by either party or agents of either party that are not contained in this contract, shall be valid or binding. This contract may not be enlarged, modified or altered except in written amendments.

IN WITNESS THEREOF, the parties have executed this contract on the dates set out below.

CONTRACTOR	**MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES**
_____ *Signature of Authorized Agent* *Date*	_____ *Sara Loewen,* *Date* *Intergovernmental Human Services Bureau Chief* *Human and Community Services Division*
_____ *Title of Authorized Agent* *(Owner, Partner, Manager, Bookkeeper, President/Vice President, Office Clerk)*	

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

PAYMENT ADDRESS FORM

Mailing Address to Receive Payments is Different than the Address on W-9 form

Complete and return this form only if the mailing address to receive Low Income Home Water Assistance Program (LIHWAP) benefit payments is **different** than the mailing address on the W-9 form.

Vendor Name:		
Address for payments, different from W-9:		
City:	State:	Zip Code:
Tax Identification Number From W-9:		
Telephone Number:		
Fax Number:		
Email:		

Standard Form 1199A (EG)
(Rev. June 1987)
Prescribed by Treasury Department
Treasury Dept. Cir. 1076

OMB No. 1510-0007

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER

Prefix Suffix

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*

- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed. Salary/Mil. Civilian Pay
- ☐ Mil. Active
- ☐ Mil. Retire.
- ☐ Mil. Survivor
- ☒ Other LIHWAP *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE	AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE	DATE
SIGNATURE	DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE
SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS
Montana Department of Public Health and Human Services	PO Box 202956 Helena, MT 59620

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER CHECK DIGIT

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE

Financial institutions should refer to the GREEN BOOK for further instructions.
THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

Reset

BURDEN ESTIMATE STATEMENT

The estimated average burden associated with this collection of information is 10 minutes per respondent or recordkeeper, depending on individual circumstances. Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be directed to the Financial Management Service, Facilities Management Division, Property & Supply Section, Room B-101, 3700 East-West Highway, Hyattsville, MD 20782 or the Office of Management and Budget, Paperwork Reduction Project (1510-0007), Washington, D.C. 20503.

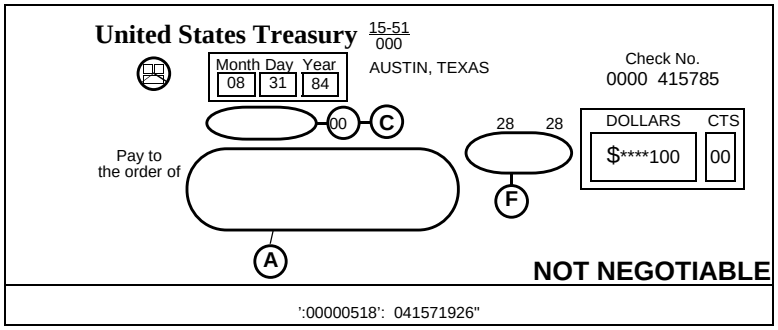
PLEASE READ THIS CAREFULLY

All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

INFORMATION FOUND ON CHECKS

Most of the information needed to complete boxes A, C, and F in Section 1 is printed on your government check:

- (A) Be sure that payee's name is written exactly as it appears on the check. Be sure current address is shown.
- (C) Claim numbers and suffixes are printed here on checks beneath the date for the type of payment shown here. Check the Green Book for the location of prefixes and suffixes for other types of payments.
- (F) Type of payment is printed to the left of the amount.



SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

CHANGING RECEIVING FINANCIAL INSTITUTIONS

The payee's Direct Deposit will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the Direct Deposit. To effect this change, the payee will complete a new SF 1199A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is complete, i.e. after the new financial institution receives the payee's Direct Deposit payment.

FALSE STATEMENTS OR FRAUDULENT CLAIMS

Federal law provides a fine of not more than $10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.