Emergency Home Energy Assistance for the Elderly Program - Application

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| Section One: Applicant (Aged 60 and older) Information |  |
| Name: (First, M, Last) | ☐ Heating Season ☐ Cooling Season |  |
| Date of birth:  | Age:  | SSN:  |  |
| Service address:  | **Date Stamp** |
| City:  | Florida County:  | ZIP Code:  | Intake worker’s name: |
| Sex: ☐ Male ☐ Female  | Number of people in the household:  | Phone: |  |
| Marital Status: ☐ Married ☐ Partnered ☐ Single ☐ Separated ☐ Divorced ☐ Widowed  | Phone: |
| Race: ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other  |
| Ethnicity: ☐ Hispanic/Latino ☐ Other  | Primary Language: ☐ English ☐ Spanish ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does client have limited ability reading, writing, speaking, or understanding the English language? ☐ Yes ☐ No  |
| Is the client a veteran? ☐ Yes ☐ No  | Was client referred to the local Veteran’s Affairs office? ☐ Yes ☐ No ☐ N/A  |
| Applicant’s income type(s):  | Applicant’s monthly income amount: |
| Section Two: Additional Household Members Information |
| Name:  | Income type(s): |
|  | Age:  | SSN: | Monthly income amount:  |
| Name:  | Income type(s): |
|  | Age: | SSN: | Monthly income amount:  |
| Name:  | Income type(s): |
|  | Age: | SSN: | Monthly income amount:  |
| Name:  | Income type(s): |
|  | Age: | SSN: | Monthly income amount:  |
| Name:  | Income type(s): |
|  | Age: | SSN: | Monthly income amount:  |
| Section Three: Household Characteristics |
| Is there a child 5 years of age or younger in the household? ☐ Yes ☐ No If Yes, select all that applies: ☐ 0-2 years old ☐ 3-5 years old |
| Is there an individual with a disability in the household? ☐ Yes ☐ No  |
| Is the applicant a U.S. citizen or an alien lawfully admitted for permanent residence? ☐ Yes ☐ No  |
| Is the applicant a homeowner? ☐ Yes ☐ No  |
| Does applicant live in government subsidized housing, such as Section 8? ☐ Yes ☐ No If yes, provide the complex name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, does the household receive an energy subsidy? ☐ Yes ☐ No  |
| Does applicant live in a student dormitory, adult family care home, or any kind of group living facility? ☐ Yes ☐ No If yes, provide the facility name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Section Four: Heating and Cooling Information |
| Have you or any member of your household received energy assistance in the current season? ☐ Yes ☐ No If yes, provide the name of Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Type of Assistance: ☐ Crisis ☐ Home Energy ☐ Weather-Related Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| What is the primary source of home heating? (select one) ☐ Electricity ☐ Natural Gas ☐ Propane ☐ Wood/Coal ☐ Refillable Fuels  |
| Does household use supplemental heating source? ☐ Electricity ☐ Wood/Coal ☐ N/A  |
| Air conditioning unit type? ☐ Central A/C ☐ Window/Wall A/C ☐ Fans ☐ Other – specify (including evaporative cooler) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Section Five: Energy Crisis Explanation | Client Attestation and Signature |
| ☐ Home cooling or heating energy source has been disconnected. | The information provided on this application, is to the best of my knowledge, true and complete. I understand that priority in providing assistance will be given to those households with the lowest income and greatest need, i.e. those households in which the elderly, disabled, medically needy, or children reside. I authorize the agency to make benefit payments directly to my energy supplier. I am aware that after I have provided all the information requested to determine my eligibility, if I am applying for crisis assistance, the agency has 18 hours to act upon my application with an eligible action. I am also aware that if I am not approved or denied within the time allowed, or not approved for the correct amount, I have a right to appeal the decision. (If you sign with an “X” two witnesses are required.) |
| ☐ Received notification that cooling or heating energy source is going to be disconnected. |
| ☐ Cooling or heating energy source bill is delinquent or past due. |
| ☐ Cooling or heating energy source bill or notice’s due date has lapsed. |
| ☐ Unable to get delivery of heating fuel, is out of heating fuel, or in danger of being out of fuel for heating. |
| ☐ My home’s energy equipment is inoperable. |
| ☐ I need a deposit. | Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

***ALL CLIENTS SHOULD SIGN THE WAIVER, AUTHORIZING THE RELEASE OF GENERAL AND/OR CONFIDENTIAL INFORMATION FOR LIHEAP/EHEAP FEDERAL REPORTING.***

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| Emergency Home Energy Assistance for the Elderly Program - Eligibility Worksheet |
| Section Six: Income Eligibility Determination |
| Annualize all household income.  | Staple calculator tape here showing income calculations or write calculations in this space. | **Poverty Guidelines effective 10/01/2019.** |
| 1. Add all gross monthly earned and unearned income from the past 30 days of all household members.
 | Select the annual income limit by household size: 150% of Poverty 50% of Poverty☐ 1……….$18,735 $ 6,245☐ 2……….$25,365 $ 8,455☐ 3……….$31,995 $10,665☐ 4……….$38,625 $12,875☐ 5……….$45,255 $15,085☐ 6……….$51,885 $17,295☐ 7……….$58,515 $19,505☐ 8……….$65,145 $21,715(Add $6,630 for each additional member of family unit with more than 8 members.) |
| 1. Add Medicare Premium ($135.50), if not included in SSA amount.
 |
| 1. Add Medicare Part D, if applicable.
 |
| 1. To annualize, multiply the monthly total by 12 months.
 |
| Annual Household Income $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| If the total annual household income is less than 50% of the current Federal Poverty Guidelines for household size (using chart above), and no one in the household is receiving SNAP assistance, the applicant must provide a signed statement of how basic living expenses (i.e., food, shelter and transportation) are provided for the household.  |
| Section Seven: Vendor, Benefit, and Verification Information |
| **Energy Vendor #1** Name: | **Other Vendor #1** Name:  | Contact made with LIHEAP provider to verify previous crisis assistance. Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Has the applicant received LIHEAP crisis assistance during the current season? ☐ Yes ☐ No  |
| Account Number:  | Account/Voucher Number: | Date: |
| Minimum Amount Due:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Amount Due:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Verification and CommitmentContact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ☐ Blanket☐ Portable Fan☐ Space Heater☐ Window A/C | ☐ Repair Existing Heating or Cooling Equipment☐ Emergency Shelter☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | If the minimum amount due is more than the past due amount, did the energy vendor verify that this amount is required? ☐ Yes ☐ No ☐ N/A |
| **Energy Vendor #2** Name: | **Other Vendor #2** Name:  |
| Account Number:  | Account/Voucher Number: | Date: | If the minimum amount due to resolve the crisis is more than the maximum allowed ($600), explain how the balance of the amount due will be paid if approved for EHEAP crisis assistance. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Minimum Amount Due:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Amount Due:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Verification and CommitmentContact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ☐ Blanket☐ Portable Fan☐ Space Heater☐ Window A/C | ☐ Repair Existing Heating or Cooling Equipment☐ Emergency Shelter☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **Total Energy Vendors**
 | **$** | 1. **Total Other Vendors**
 | **$** | Is the name on the fuel bill that of the applicants? ☐ Yes ☐ No If no, provide name on bill:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **Energy Subsidy**
 | **$** | **Total EHEAP Benefit****Add** **Total Energy Vendor (4) & Total Other Vendor (4)** | **$** |
| 1. **Water, Sewer, Garbage, Fire, etc.**
 | **$** |
| 1. **Deduct (2&3) from (1)**
 | **$** |
| Section Eight: Weatherization Assistance Program (WAP) Referral |
| If the applicant is a homeowner, has he/she received more than three LIHEAP or EHEAP benefits in the last 18 months? ☐ Yes ☐ No ☐ N/A |
| If the answer to the previous question is “yes”, was the applicant referred to WAP? ☐ Yes ☐ No ☐ N/A |
| If the answer to the last question is “no”, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Section Nine: Resolution of Crisis |
| Resolution of the Heating/Cooling Energy Crisis occurred within 18 hours, by the following eligible action: (Select all that apply) |
| ☐ Approval of application | ☐ EHEAP benefit prevented disconnection |
| ☐ Commitment made to vendor | ☐ EHEAP benefit restored energy already disconnected |
| ☐ Denial of Application, pending additional information | ☐ Yes, client signed waiver |
| ☐ Denial of Application, ineligible | ☐ No, client refused to sign waiver |
| ☐ Written referral and assistance to access other community resources |
| Case Worker Signature | Approval Signature |
| **I have determined the eligibility of the applicant.** I am not the applicant, nor am I a friend, relative, or employee of the applicant. | The application and eligibility determination must be reviewed for errors and appropriate file documentation prior to making payment. **I have reviewed and approved this application for crisis assistance.** |
| Case Worker’s Name: | Supervisor/Peer’s Name: |
| Case Worker’s Signature: | Supervisor/Peer’s Signature: |
| Date: | Date: |
| Agency Name: | Agency Name: |

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