DEPARTMENT OF ELDER AFFAIRS
EMERGENCY HOME ENERGY ASSISTANCE FOR THE ELDERLY APPLICATION

☐ Heating Season (October 2006 - March 2007) ☐ Cooling Season (April 2007- September 2007) **DATE STAMP ↑**
☐ Heating Season (October 2007 - March 2008)

APPLICANT'S CIRTS DATA:

Name: (Household member age 60 or older)		Medicaid Number:	Social Security Number/I.D.:	
Consumer Type: ☐ Caregiver (C) ☐ Elder Recipient (E)		Are you the caregiver of a live –in child or grandchild? ☐ Yes ☐ No		
Physical Address: (Number and Street)		City:	State: FLORIDA / ZIP:	County:
Phone Number:	Does the applicant reside in public housing? ☐ Yes ☐ No	Application Date:	Assessment Site: ☐ Home (CH) ☐ Provider (P) ☐ Other (O)	Assessment Type: EHEAEP (O)
Date of Birth:		Sex: ☐ Female ☐ Male	U.S. Citizen or Legal Resident? ☐ Yes ☐ No	

RACE: ☐ White (W) ☐ Black (B) ☐ Native Am. (NA) ☐ Asian/Pacific (A) ☐ Other (O)
ETHNICITY: ☐ Hispanic (H) ☐ O – Other (O)
Primary Language: _____

Referral Source: ☐CARES (C) ☐APS (A) ☐ Lead Agency (L) ☐ Hospital (H) ☐ Upstreaming/CARES (U) ☐ Other (O) ☐ Self (S)
If at Imminent Risk of NH placement, check: ☐ Imminent Risk (IM)
If transitioning out of a Nursing Home, check: ☐ Transition from NH (TRNH)
If APS, check level of risk: ☐ High (H) ☐ Moderate (M) ☐ Low (L)
Date of Referral: _____

Marital Status: ☐Married* ☐Single ☐Separated ☐Widowed ☐Divorced
*Couple's monthly income/assets are required

Does the applicant have a primary caregiver? ☐Yes ☐No

Living Situation: ☐With Caregiver ☐With Other ☐Alone

Need outside assistance to evacuate? ☐ Yes ☐ No

Registered with county special needs registry? ☐Yes ☐ No

Applicant's Monthly Income: $_____ *Couple's Monthly Income: $_____ Receiving Food Stamps? ☐ Yes ☐ No

Household's Annual Income (from page 2) $_____

INCLUDE DOCUMENTATION OF HOUSEHOLD INCOME OR SELF-DECLARATION IN THE APPLICANT'S FILE.

Estimated Total Individual; Assets:
☐$0 - $2000(M) ☐$2,001 -$5,000 (N) ☐ Over $5,000(P)

*Estimated Total Couple; Assets:
☐$0 - $3000(M) ☐$3,001 -$6,000 (N) ☐ Over $6,000(P)

Status: ☐ GOAH ☐ TRNE (check one) Eligibility Code: INC. Provider ID #: _____ Worker ID #: _ _____

Primary source of heating home:	Is there an individual with a disability in the household?	Is there a child 5 years old or younger in the household?	Number of household members who meet the citizenship/alien status requirements
☐ Electric ☐ Gas ☐Fuel Oil ☐ Wood ☐ Kerosene	☐ Yes ☐ No	☐ Yes ☐ No	_____

OTHER ELIGIBILITY DATA:

1. Give the following information for applicant first, then each person living in your home. If more than five persons live in your home, list the additional persons, giving the same information, on a separate sheet of paper and attach it to this form.

Name	SSN/ID	Age	DOB	Relationship To Applicant	Type Income*	Annual Income
				SELF		

*Type income includes: Wages, self-employment, SSA, SSI, regular gifts, unemployment comp., retirement benefits, TANF/WAGES, pension, interest on savings, etc.

2. Do you share your living or mailing address with others who are not a part of your home? ☐Yes ☐ No If yes, provide their names: _____; _____; _____.
3. Is anyone in your home not a U.S. citizen or not an alien lawfully admitted for permanent residence? ☐Yes ☐ No If yes, list the names and alien status under the Immigration and Naturalization Act: _____.
4. (PSA 1 ONLY) Are you or is anyone in your household a member of the Poarch Indian Tribe? ☐Yes ☐ No
5. Check the programs you / anyone in your household are currently eligible for /are receiving assistance from:
   ☐Food Stamps ☐Community Services Block Grant (CSBG) ☐Weatherization Assistance Program (WAP) ☐ None of these
6. Have you or any member of your household received energy assistance in the current season? ☐Yes ☐ No If yes, complete the following:
   Name of Agency: _____ Type of assistance: ☐ Crisis ☐ Home energy ☐ Weather-related Date: _____
7. I certify that I need the following to resolve my heating/cooling crisis:
   a. Need to pay utility bill to continue: ☐ heating ☐ cooling
   b. Need to repair: ☐ heating system ☐ cooling system
   c. Need to pay deposit to turn on utilities for: ☐ cooling or ☐ heating
   d. Need to purchase: ☐ space heater ☐ blanket ☐ wood ☐ fuel oil ☐ other heating fuel ☐ A/C ☐ fan
8. Is the cost of home energy included in your rent? ☐Yes ☐ No If yes, provide the name/telephone number of your landlord (Attach a letter from the landlord confirming your rent includes utilities): Landlord: _____ Account #: _____ Telephone #: _____
9. Do you live in a government subsidized bousing project, Section 8 housing, dormitory, nursing home, adult foster home, or any kind of group living facility? ☐Yes ☐ No If yes, complete the following: Name of place where you live: _____ Address: _____ City/State/Zip: _____ County: _____
10. What is the primary source of energy you use to HEAT/COOL your home during the season for which you are applying? Choose one and provide the information below:
    ☐Electric ☐Natural Gas ☐Propane ☐Fuel Oil ☐Wood ☐Air Conditioning ☐Fans ☐Other - specify

Company Name	Customer Name on Account	Customer Account #	Company's Telephone #

11. If not given in question 10, provide the following information about your electric company:

Company Name	Customer Name on Account	Customer Account #	Company's Telephone #

Please carefully read the following statement and sign:
The information above 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, medical 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, if I am applying for crisis assistance, the agency has 48 hours; 18 hours if my situation is life threatening, to approve or deny my application. 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 an appeals hearing. (If you sign with an "X" two witnesses are required.)

Your Signature: _____ Date: _____ Caseworker: _____

****FOR OFFICE USE ONLY****

1. **Household Income Computation - List sources and amounts of all household income.**
(Computation is not necessary if consumer automatically qualifies. Documentation must be attached.)

Gross Earned Income Source: | **Income per month:**

_____ $ _____
_____ $ _____
_____ $ _____
_____ $ _____
_____ $ _____

Gross Unearned Income Source: | **Income per month:**

_____ $ _____
_____ $ _____
_____ $ _____
_____ $ _____

TOTAL $ _____ **Add in Medicare Premium if not included in SSA above ($93.50)**

Consumer automatically qualifies for EHEAP if:

- ☐ Consumer has a home energy emergency, AND
- ☐ Receives Food Stamps, or
- ☐ Applied for Weatherization Assistance Program and is currently eligible, or
- ☐ Applied for Community Services Block Grant and is currently eligible

Annual income limit* (150% poverty) by household size:

1.....$15,315
2.....$20,535
3.....$25,755
4.....$30,975
5.....$36,195
6.....$41,415
7.....$46,635
8.....$51,855

(Add $5,220 for each additional member of family units with more than 8 members.)

Number of persons in household: _____

Annual Income Limit: $_____

*Poverty Guidelines effective 1/24/2007

2. **Show calculations below:**
Total Gross Monthly Earned Income: $ _____
Total Gross Monthly Unearned Income: + $ _____
Total Gross Monthly Income: = $ _____ **(monthly x 12 = annual)**
Total Gross Annualized Income: $ _____

3. **Income is at or below the income limit? ☐ Yes ☐ No If household income is less than $738 a year, explain how food, shelter, clothing, transportation and home utilities are purchased:** _____

4. **Date verified household has not received DCA LIHEAP Crisis Benefits: Contact Person:** _____ **Date:** _____

5. **If the applicant is a homeowner and has received more than three LIHEAP or EHEAP payments within an 18-month period, has a referral been made to the WAP? ☐Yes ☐ No ☐ N/A If no or N/A, explain why:** _____

6. **Check verification of Energy Crisis. If not an eligible crisis, deny. Verify the benefit will resolve the crisis. If the maximum will not resolve the crisis and arrangements to resolve cannot be made, deny. This section must be completed.**
   a. **Is the applicant in a crisis situation?** ☐Yes ☐No
   b. **Is the household in a life-threatening situation? (if yes, 18 hr. applies in next question)** ☐Yes ☐No
   c. **Does the 18 hour or the 48 hour rule apply?** ☐ 18 hr ☐48 hr
   d. **Will the EHEAP benefit resolve the crisis situation?** ☐Yes ☐No

7. **If the household is still eligible, call the vendor to verify the minimum amount needed and record below (explain different amount paid on the line below):**
   a. **Vendor:** _____ **Minimum Amount:** _____ **Contact Person:** _____ **Date of Contact:** _____
   b. **Is the name on the fuel bill that of a household member? ☐Yes ☐No If no, explain:** _____
   c. **Provide the following information about the benefit(s) provided:**

Company Name	Customer Name On Account	Customer Account #	Company's Telephone #	Service/Product*	Amount Paid from EHEAP

*Examples: Electricity, deposit, propane, fuel oil, wood, blanket, fan, repair to heating system, repair to cooling system, late fees/penalties.

   d. **If over $400, explain how excess cost will be met:** _____

8. **Resolution of Energy Emergency:**
   a. **Case Approved (check one)** ☐Yes ☐No **Date:** _____
   b. **Date of resolution:** _____ **Time of Resolution:** _____ **Extension Date:** _____
   c. **Was the 18/48 hour rule met?** ☐Yes ☐No d. **Written notification sent to applicant?** ☐Yes ☐No
   e. **How was authorization/notification made to the vendor?** _____

PLACE COPY OF APPROPRIATE NOTICE IN THE APPLICANT'S FILE.

9. **Denial of Assistance: If energy assistance was denied, explain:** _____

I have determined the eligibility of the applicant. I am not the applicant, nor am I a friend, relative or employee of the applicant.

Caseworker's Name (Print) _____ **Signature:** _____
Date: _____ **Agency:** _____

Application must be reviewed for mistakes and appropriate file documentation prior to payment:

Supervisor/Edit Staff Name (Print) _____ **Signature:** _____
Date: _____ **Agency:** _____

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