

Notice of Instruction

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West Central Florida
Area Agency on Aging, Inc.



Assistance. Advocacy. Answers on Aging.

Notice of Instruction Number: 032708-EHEAP Application Update-KP

TO: All EHEAP Providers
FROM: Katie Parkinson, Senior Program Manager (Extension 5574)
DATE: March 27, 2008
SUBJECT: Revised EHEAP Application for 2008-2009 Contract Year
cc: Program Managers

The purpose of this Notice of Instruction is to notify all EHEAP application for the contract year commencing April 1, 2008 has been revised. The revised application, DOEA Form 114-Rev. January 4/1/2008 is attached. All applications for emergency home energy assistance on or after April 1, 2008 must be completed on the revised application. The EHEAP Application instructions have been revised to reflect the updated application. Please note the following minor revisions to the application:

- Questions 8 and 9 on Page 1 were not revised but will need to be carefully answered.
- Question 3 on Page 2 has been revised from \$738 a year to 50% of the Federal Poverty Level.
- Question 6 a-d on Page 2 was reformatted slightly.
- Question 7c on Page 2 has been added to allow the agency to calculate the energy allowance or subsidy, if applicable.
- Question 7d (previously 7c) on Page 2 was revised to reflect the amount paid with EHEAP minus the subsidy/allowance.
- Question 7d has been renumbered and is now 7e.

The revised application will be in effect with the 2008 – 2009 contract, it is necessary to begin using it with the 2008 – 2009 EHEAP funding.

Thank you for your continued commitment to Florida's elders. Should you require additional information, please contact your program manager.

Attachments

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GENERAL REVENUE THROUGH THE DEPARTMENT OF ELDER AFFAIRS.

Department of Elder Affairs
Emergency Home Energy Assistance for the Elderly Program (EHEAP)
Application Instructions

APPLICANT'S CIRTS DATA

The top section of the front/first page is information that will be entered into the Client Information Record and Tracking System (CIRTS).

Top left corner: Check off the cooling/heating season for which assistance is being requested.

Top right corner: Place the date stamp here or write in the date. This date documents the day on which the application is first received by the provider agency.

ROW 1

- Box 1. Legibly write the **name** of the “household member age 60 or older” (elder) for whom the application is being made.
- Box 2. Legibly write the **Medicaid number** of the elder.
- Box 3. Legibly write the **Social Security number** of the elder. If there is no SSN, write the ID number from the elder’s document that shows his/her legal residency. If necessary, create a pseudo ID#.

ROW 2

- Box 1. For **Consumer Type**, indicate if the elder, for whom the application is being made, is a caregiver. If so, check “caregiver” and if not, check “elder recipient.”
 - Box 2. If the **caregiver** box was checked, it is important to know whether the elder is the caregiver for a live-in child or grandchild under the age of 19? If so, circle which and check “yes.” If not, check “no.”
- NOTE:** If the elder is the caregiver for a live-in child or grandchild under the age of 19, a referral should be made to the Older Americans Act, Title III E Caregiver program.

ROW 3

- Box 1. Legibly write the **street number and name** where the elder lives.
- Box 2. Legibly write the name of the **city**.
- Box 3. This is filled out for you. This is a Florida program.
- Box 4. Legibly write the 5-digit **zip code** for the address.
- Box 5. Legibly write the **county** number that goes with the address. (See county listing on the pop-down menu for two digit code.)

ROW 4

- Box 1. Legibly write the **phone number** of the elder. If the elder has no phone, write the phone number for a telephone where the elder can be reached.
- Box 2. If the elder lives in **public housing**, check “yes.” If not, check “no.”
- Box 3. For **Application Date**, legibly write the date when the application is being completed.
- Box 4. For **Assessment Site**, check the box indicating where the application is being completed. Is it at the elder’s “home,” at the agency that is the “provider” of EHEAP services (provider), or somewhere other than the elder’s home or the provider’s office (“other”)?
- Box 5. This is filled out for you. The application is for the EHEAP Program.

ROW 5

Box 1. Legibly write the **date of birth** of the elder. (month, day and year)

Box 2. For **Sex**, check the correct box - Female or Male.

Box 3. If the applicant is a **U.S. citizen or a legal resident**, check “yes.” If not, check “no.”

ROW 6

Box 1. **Race**: Check the racial category that best describes the elder.

(White, Black, Native American, Asian/Pacific, or Other)

Ethnicity: Check “Hispanic” if this describes the ethnicity of the elder.

For any other ethnicity, please check “other.”

Primary Language: Legibly write the primary language used by the elder.

Box 2. **Referral Source**: Check the box of the entity/person referring the elder for this service.
(CARES, APS, Lead Agency, Hospital, Upstreaming/CARES, Other, or Self)

If the elder is classified as being at Imminent Risk of Nursing Home Placement, check the “IM” box. Otherwise check nothing on this line.

If the elder is transitioning out of a Nursing Home, check the “TRNH” box. Otherwise check nothing on this line.

If the elder was referred by Adult Protective Services, check the level of risk associated with the referral. (High, Moderate, or Low)

On the line provided, legibly write the date the referral was made to the EHEAP program from the checked source.

ROW 7

Box 1. Check the description that presently fits the elder’s **marital status**. (Married, Single, Separated, Widowed, or Divorced)

NOTE: If the elder is married, the monthly income and assets of the couple are required.

Box 2. Check “yes” if the elder has a **primary caregiver**. Check “no” if he/she does not have a primary caregiver.

NOTE: A primary caregiver is any person who cares for someone on a regular basis and can be depended on to provide help as needed with Activities of Daily Living and Instrumental Activities of Daily Living. He/she may or may not live with the elder.

Box 3. Check the choice that describes the elder’s **living situation**. (With Caregiver, With Other, or Alone)

Box 4. Does the elder need outside **assistance in order to evacuate** his/her home? If so, check the “yes” box. If not, check the “no” box.

Box 5. Is this elder registered with the county **special needs registry**? If so, check the “yes” box. If not, check the “no” box.

NOTE: If Box 4 is checked yes, and box 5 is checked no, a referral should be made for the elder to the county special needs registry.

ROW 8

Box 1. Legibly write the elder’s GROSS **individual monthly income** on the line provided.

Box 2. Legibly write the elder AND spouse’s GROSS **couple monthly income** as a couple on the line provided. (This box must be completed if Box 1 on Row 7 was checked as “Married.”)

Box 3. Check “yes” if the elder is already **receiving Food Stamps**. Check “no” if he/she is not already receiving Food Stamps.

ROW 9

Box 1. Legibly write the household's GROSS **annual income** on the line provided. This comes from the bottom line of the first box on the back/second page of the application.

NOTE: Documentation paperwork or statement of self-declaration of income is kept in the elder's EHEAP file. Enter this amount on the CICLIENT screen in CIRTSS.

Box 2. Check the box that describes the elder's **individual asset level**.
(\$0-\$2,000, \$2,001-\$5,000, or Over \$5,000)

Box 3. Check the box that describes the **couple asset level** for the elder AND his/her spouse.
(\$0-\$3,000, \$3,001-\$6,000, or Over \$6,000)

ROW 10 (NOTE: to be completed upon crisis resolution or denial)

Box 1. Check "GOAH" if the goal has been achieved.

Check "TRNE" if the case was terminated before the goal was achieved.

Box 2. This is completed for you. ("INC" means that income was the eligibility source.)

Box 3. Legibly write the provider ID # for the **provider agency** which employs the person completing the form and associated CIRTSS data entry.

Legibly write the **worker ID** # for the person completing the form.

ROW 11

Box 1. Check off the **primary source of heating** product used in the client's home. (electric, gas, fuel oil, wood or kerosene)

Box 2. Check "yes" if there is an **individual with a disability** in the household? If not, check "no." Simply being over 60 years of age is not considered a disability.

Box 3. Check "yes" if there is a **child who is 5 years old or younger** in the home. If not, check "no."

Box 4. Legibly write the **number of household members** who meet the citizenship/alien status requirements.

Enter the information from Row 11 - boxes 1, 2, and 3 on the CICLIENT Screen in CIRTSS.

OTHER ELIGIBILITY DATA:

1. For the elder first and then for all other persons living in the household, legibly write information concerning: name, SSN or ID, age, date of birth, relationship to the elder, type of income received (wages, self-employment, SSA, SSI, regular gifts, unemployment compensation, retirement benefits, TANF/WAGES, pension, interest on savings, etc.), and annual income. NOTE: If there are more than 5 people living in the home, a separate sheet of paper with their additional information will have to be attached.

2. Check "yes" if the elder shares his/her address or mailing address with someone who is not a part of his/her home. If yes, provide the names of these persons. If not, check "no."

3. If anyone in the household is not a U.S. citizen or an alien lawfully admitted for permanent residence, check "yes." If yes, legibly write the name of each individual as well as the person's alien status under the Immigration and Naturalization Act. If not, check "no."

4. If the elder or anyone in the household is a member of the Poarch Indian Tribe, check "yes." If not, check "no." This question will probably only be applicable in the counties of PSA 1.

5. If the elder or anyone in the household receives assistance from a Community Service Block Grant, Weatherization, or Food Stamps, check the box that is appropriate. Elder applicants with an energy crisis and receipt of one of these types of assistance automatically qualify for EHEAP benefits.

6. If the elder or anyone else in the household received energy assistance (through EHEAP or LIHEAP) in the current season, check "yes." If not, check "no." For anyone who has received energy assistance, legibly write the name of the agency that supplied the assistance, as well as the type of assistance (crisis, home energy, weather-related), and the date that the assistance was received.

7. Check off the boxes that apply to the elder's situation concerning what is needed to resolve his/her cooling or heating crisis.

- a. Need to pay utility bill to continue: "heating" or "cooling." Check which is correct.
- b. Need to repair: "heating system" or "cooling system."
- c. Need to pay deposit to turn on utilities for: "cooling" or "heating."
- d. Need to purchase an item: "space heater, blanket, wood, fuel oil, other heating fuel, air conditioning, a fan."

8. Check "yes" if the cost of home energy is included in the elder's rent. Attach a letter from the landlord confirming the cost being included in the rent. Legibly write the landlord's name, account number, and telephone number on the form. If not, check "no."

9. Check "yes" if the elder lives in a government subsidized housing project, Section 8 housing, dormitory, nursing home, adult foster home, or any kind of group living facility. Legibly write the name of the living place, address, city, state, zip, and county on the form. If not, check "no."

10. Check the primary source of energy used in heating/cooling the home during the season for which the elder is applying for assistance. The choices are: electric, natural gas, propane, fuel oil, wood, air conditioning, fans, and other. Legibly write the name of the company supplying the fuel needed for this season, the customer name on the account, the customer account number, and the company's telephone number on the form.

11. If the payment being made to the provider in #10 above is not the maximum amount, a payment might also be made to the electric company. Legibly write the name of the company supplying the electricity, the customer name on the account, the customer account number, and the company's telephone number on the form.

Signature Block:

The applicant will read the statement at the end of the application and will sign and date it, with the caseworker also signing as a witness. The applicant is declaring that:

- a. the information is true and complete;
- b. he/she understands that households with the greatest need and lowest income will be prioritized for assistance;
- c. he/she understands that the energy supplier is paid directly;
- d. the administering agency has 48 hours to approve or deny the application, 18 if the situation is life threatening; and that
- e. a hearing can be requested if the application is not approved within the time allowed or is not approved for the correct amount.

NOTE: If the applicant signs with an “X”, two witnesses are required.

Back of Page /PAGE 2 “Office Use Only”

1. List all gross monthly household earned income with its source and amount. List all gross monthly household unearned income with its source and amount. Add up income to determine the total gross monthly income.

*Note: if the Medicare Premium was not included in the Social Security amount, add in the amount indicated on the most recent application.

2. Calculate the monthly income, by adding the earned income to the unearned income. Calculate the annualized income by multiplying the monthly income by 12. Write that amount on the last line under #2.

Refer to the annual income limit chart on the top right of the page. Note the number of persons living in the elder’s household and write on the line below the chart. Write the annual income limit associated with that number of persons from the chart on the other line provided. The Poverty Guidelines effective date has been added to the application for your reference.)

3. Compare the Total Gross Annualized Income (in the left box) to the Annual Income Limit amount (in the right box). If the total gross annualized income amount is at or below the annual income limit amount, check “yes.” If not, check “no.”

If the household income is less than 50% of the Federal Poverty Level, the applicant must explain how food, shelter, clothing, transportation, and home utilities are purchased.

4. The person from the agency who is completing the application will verify that the household has NOT received LIHEAP crisis benefits during the current season. If not already known, also ask about LIHEAP assistance in the past 18 months for answering #5. The contact person’s name at the LIHEAP agency who provided the documentation will be legibly written on the line provided along with the date that the information was received.

5. A homeowner with an energy crisis, who has received three episodes of energy assistance (through EHEAP or LIHEAP) within the last 18 months, is probably in need of assistance from the Weatherization Assistance Program (WAP) to make the house more energy efficient. Check “yes” if the applicant is a homeowner. Check “no” if the applicant is not a homeowner.

a. If the referral to the WAP has been made, check “yes.” If not, check “no.” If the response is “no or N/A,” explain why on the line provided.

6. This is where the staff verify the existence of an energy crisis. Instructions tell the staff to deny the application if it is not an eligible crisis. Denial is also required if the maximum EHEAP payment of \$400 will not resolve the crisis and arrangements cannot be made to cover the rest of the need and resolve the crisis.

a. Check “yes” if this meets the crisis criteria. If not, check “no.”

b. Check “yes” if this is a life-threatening situation. If not, check “no.”

c. Check “18 hour” if this is a life-threatening situation and “48 hour” if it meets the crisis criteria but is not life-threatening.

d. Check “yes” if the EHEAP payment will resolve the crisis situation. If not, check “no.”

7. If the yes/no questions in #6a and 6d were answered “yes,” then the staff will call the energy vendor to verify what the minimum payment would be to resolve the crisis. If this is different than the amount on the cut off notice, an explanation must be provided in the space below.

- a. Legibly write the vendor’s name, minimum amount, contact person at the vendor agency, and the date the contact was made.
- b. Document if the name on the fuel bill is one of the household members? If “no,” then explain.
- c. Write in the EHEAP benefit amount.

Subtract the amount of the allowance or subsidy available to the applicant during the period covered by the utility bill from the allowable EHEAP benefit calculated for the household. Attach documentation from the landlord indicating the amount of the allowance or subsidy. The applicant is responsible for this portion of the delinquent utility bill.

Enter N/A if this does not apply for this applicant.

Enter the Total EHEAP benefit amount.

- d. Legibly write on the chart information about what is being provided:

Company name

Customer name on the account

Customer account number

Company’s telephone number

Service provided – electricity, deposit, propane, fuel oil, wood, blanket, fan, repair to heating system, repair to cooling system, late fees/penalties.

Amount paid from EHEAP, minus the allowance or subsidy

- e. Explain how any costs over the maximum \$400 EHEAP payment will be met.

8. Resolution information.

- a. If the case was approved, check “yes.” If not, check “no.” Note the date.
- b. Note date and time of resolution. Also note if there is an extension date. Extension date is the future date the energy provider has set for shutting off power if funds are not received.
- c. If the 18/48 rule was met, check “yes.” If not, check “no.”
- d. The provider will, within 15 days of receiving the consumer’s application, furnish in writing to all consumers a Notice of Approval that includes the type and amount of assistance to be paid on their behalf or a Notice of Denial, which includes appeal information. Check “yes” if this has been provided. If not, check “no.” Include a copy of the notice in the applicant’s file.
- e. Write on the line provided how authorization/notification was made to the vendor about the payment that is being made.

9. Denial of assistance: If the application had to be denied, give a detailed explanation of why the application could not be approved.

Signature Block:

The caseworker LEGIBLY writes his/her name on the line provided. He/she then signs and dates the form, noting the agency’s name. He/she is testifying that eligibility was determined and that there is no conflict of interest with the applicant. The supervisor/edit staff LEGIBLY writes his/her name on the line provided. He/she then reviews and signs off that appropriate documentation was made prior to payment being made, noting the agency’s name, and dates the form.

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

☐ Heating Season (October 2007 - March 2008)
☐ Heating Season (October 2008 - March 2009)

☐ Cooling Season (April 2008- September 2008)

DATE STAMP ↑

APPLICANT'S CIRTS DATA:

| | | | | | |
|---|--|--|--|--|--|
| Name: (Household member age 60 or older) | | Medicaid Number: | Social Security Number/L.D.: | | |
| Consumer Type: <input type="checkbox"/> Caregiver (C) <input type="checkbox"/> Elder Recipient (E) | | Are you the caregiver of a live -in child or grandchild? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Physical Address: (Number and Street) | | City: | State: FLORIDA | ZIP: County: | |
| Phone Number: | Does the applicant reside in public housing? <input type="checkbox"/> Yes <input type="checkbox"/> No | Application Date: | Assessment Site: <input type="checkbox"/> Home (CH) <input type="checkbox"/> Provider (P) <input type="checkbox"/> Other (O) | Assessment Type: EHEAEP (O) | |
| Date of Birth: | | Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male | U.S. Citizen or Legal Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| RACE: <input type="checkbox"/> White (W) <input type="checkbox"/> Black (B) <input type="checkbox"/> Native Am. (NA) <input type="checkbox"/> Asian/Pacific (A) <input type="checkbox"/> Other (O) ETHNICITY: <input type="checkbox"/> Hispanic (H) <input type="checkbox"/> O - Other (O) Primary Language: _____ | | Referral Source: <input type="checkbox"/> CARES (C) <input type="checkbox"/> APS (A) <input type="checkbox"/> Lead Agency (L) <input type="checkbox"/> Hospital (H) <input type="checkbox"/> Upstreaming/CARES (U) <input type="checkbox"/> Other (O) <input type="checkbox"/> Self (S) If at Imminent Risk of NH placement, check: <input type="checkbox"/> Imminent Risk (IM) If transitioning out of a Nursing Home, check: <input type="checkbox"/> Transition from NH (TRNH) If APS, check level of risk: <input type="checkbox"/> High (H) <input type="checkbox"/> Moderate (M) <input type="checkbox"/> Low (L) Date of Referral: _____ | | | |
| Marital Status: <input type="checkbox"/> Married* <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced *Couple's monthly income/assets are required | | Does the applicant have a primary caregiver? <input type="checkbox"/> Yes <input type="checkbox"/> No | Living Situation: <input type="checkbox"/> With Caregiver <input type="checkbox"/> With Other <input type="checkbox"/> Alone | Need outside assistance to evacuate? <input type="checkbox"/> Yes <input type="checkbox"/> No Registered with county special needs registry? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Applicant's Monthly Income: \$ _____ | | *Couple's Monthly Income: \$ _____ | | Receiving Food Stamps? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Household's Annual Income (from page 2) \$ _____ | | Estimated Total Individual; Assets: <input type="checkbox"/> \$0 - \$2000(M) <input type="checkbox"/> \$2,001 - \$5,000 (N) <input type="checkbox"/> Over \$5,000(P) | | | |
| INCLUDE DOCUMENTATION OF HOUSEHOLD INCOME OR SELF-DECLARATION IN THE APPLICANT'S FILE. | | *Estimated Total Couple; Assets: <input type="checkbox"/> \$0 - \$3000(M) <input type="checkbox"/> \$3,001 - \$6,000 (N) <input type="checkbox"/> Over \$6,000(P) | | | |
| Status: <input type="checkbox"/> GOAH <input type="checkbox"/> TRNE (check one) | | Eligibility Code: INC. | Provider ID #: _____ Worker ID #: _____ | | |
| Primary source of heating home: <input type="checkbox"/> Electric <input type="checkbox"/> Gas <input type="checkbox"/> Fuel Oil <input type="checkbox"/> Wood <input type="checkbox"/> Kerosene | Is there an individual with a disability in the household? <input type="checkbox"/> Yes <input type="checkbox"/> No | Is there a child 5 years old or younger in the household? <input type="checkbox"/> Yes <input type="checkbox"/> No | Number of household members who meet the citizenship/alien status requirements _____ | | |

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 | 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 housing 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: _____

| 1. Household Income Computation - List sources and amounts of all household income. (Computation is not necessary if consumer automatically qualifies. Documentation must be attached.) | | Annual income limit* (150% poverty) by household size: 1.....\$15,600 2.....\$21,000 3.....\$26,400 4.....\$31,800 5.....\$37,200 6.....\$42,600 7.....\$48,000 8.....\$53,400 (Add \$5,400 for each additional member of family units with more than 8 members.) | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|--|-----------------------|---|---|--------------------|-----------------------|------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Gross Earned Income Source: _____ \$ _____ _____ \$ _____ _____ \$ _____ | Income per month: _____ \$ _____ _____ \$ _____ _____ \$ _____ | Consumer automatically qualifies for EHEAP if: <input type="checkbox"/> Consumer has a home energy emergency, AND <input type="checkbox"/> Receives Food Stamps, or <input type="checkbox"/> Applied for Weatherization Assistance Program and is currently eligible, or <input type="checkbox"/> Applied for Community Services Block Grant and is currently eligible | | | | | | | | | | | | | | | | | | | | | | | | | |
| Gross Unearned Income Source: _____ \$ _____ _____ \$ _____ _____ \$ _____ | Income per month: _____ \$ _____ _____ \$ _____ _____ \$ _____ | (Add \$5,400 for each additional member of family units with more than 8 members.) | | | | | | | | | | | | | | | | | | | | | | | | | |
| TOTAL \$ _____ | | Number of persons in household: _____ | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. Show calculations below: Total Gross Monthly Earned Income: \$ _____ Total Gross Monthly Unearned Income: + \$ _____ Add Medicare Premium and/or Part D + \$ _____ Total Gross Monthly Income: = \$ _____ (monthly x 12 = annual) Total Gross Annualized Income: \$ _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. Income is at or below the income limit? <input type="checkbox"/> Yes <input type="checkbox"/> No If household income is less than 50% of the Federal Poverty Level for household size 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. Is the applicant a homeowner? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes, and the applicant has received more than three LIHEAP or EHEAP payments within an 18-month period, has a referral been made to the WAP? <input type="checkbox"/> Yes <input type="checkbox"/> No 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. <table border="0" style="width:100%;"> <tr> <td style="width:50%; vertical-align: top;"> a. Is the applicant in a crisis situation? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Is the household in a life-threatening situation? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, 18 hr. applies in next question) </td> <td style="width:50%; vertical-align: top;"> c. Does the 18 hour or the 48 hour rule apply? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Will the EHEAP benefit resolve the crisis situation? <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> </table> | | | | a. Is the applicant in a crisis situation? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Is the household in a life-threatening situation? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, 18 hr. applies in next question) | c. Does the 18 hour or the 48 hour rule apply? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Will the EHEAP benefit resolve the crisis situation? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
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| 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0" style="width:100%;"> <tr> <td style="width:50%;"> c. \$ _____ EHEAP Benefit Amount - \$ _____ Deduct the Section 8 or public housing utility allowance deduction + \$ _____ Total EHEAP Benefit Amount (see 6d above) </td> <td style="width:50%;"> (Deduct the amount of the allowance for the period covered by the delinquent utility bill, from the total benefit amount, or indicate N/A) </td> </tr> </table> | | | | c. \$ _____ EHEAP Benefit Amount - \$ _____ Deduct the Section 8 or public housing utility allowance deduction + \$ _____ Total EHEAP Benefit Amount (see 6d above) | (Deduct the amount of the allowance for the period covered by the delinquent utility bill, from the total benefit amount, or indicate N/A) | | | | | | | | | | | | | | | | | | | | | | |
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| d. Provide the following information about the benefit(s) provided: <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:25%;">Company Name</th> <th style="width:25%;">Customer Name On Account</th> <th style="width:25%;">Customer Account #</th> <th style="width:25%;">Company's Telephone #</th> <th style="width:20%;">Service/Product*</th> <th style="width:20%;">Amount Paid from EHEAP minus Subsidy/Allowance</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> | | | | Company Name | Customer Name On Account | Customer Account # | Company's Telephone # | Service/Product* | Amount Paid from EHEAP minus Subsidy/Allowance | | | | | | | | | | | | | | | | | | |
| Company Name | Customer Name On Account | Customer Account # | Company's Telephone # | Service/Product* | Amount Paid from EHEAP minus Subsidy/Allowance | | | | | | | | | | | | | | | | | | | | | | |
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| *Examples: Electricity, deposit, propane, fuel oil, wood, blanket, fan, repair to heating system, repair to cooling system, late fees/penalties. e. If over \$400, explain how excess cost will be met: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. Resolution of Energy Emergency: a. Case Approved (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ b. Date of resolution: _____ Time of Resolution: _____ Extension Date: _____ c. Was the 18/48 hour rule met? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Written notification sent to applicant? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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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: _____