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

☐ Heating Season (M	(arch 2005) 🗆 Cooli	ing S	eason (April -S	eptembe	r 2005	5) 🗆 Hea	ting Seas	on (October 2005 - M	larch 20	06) D	ATE STAMP ↑	
Name: (Household member 60 or over)				Medicaid Number:			Social Security Number/I.D.:						
Consumer Type: ☐ Caregiver (C) ☐ Elder Recipient (E)				Are you the caregiver of a 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:		Provider	(P)	Assessment Type: EHEAEP (O)	
Date of Birth:				Sex: □ Female □ M			Iale	U.S. Citizen or Legal Reside			sident?	☐ 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) 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 Does the application a primary caregi							Need outside assistance to evacuate?			□ Yes □ No			
Separated Widowed Divorced a primary careg Yes No			□With Other □A							registry? □Yes □ No			
Applicant's Monthly Income: \$ *Couple's				Monthly	Monthly Income: \$ Receiving food					stamps?			
Household's Annual Income (from page 2) \$					□\$0 - \$2000(M) □\$2,001 -\$5,000				vidual; Assets: □\$2,001 -\$5,000 ((N)			
INCLUDE DOCUMENTATION OF HOUSEHOLD INCO SELF-DECLARATION IN THE APPLICANT'S FILE. Enter on CICLIENT Screen				OME OR	*Estimated Total Couple; Assets:				uple; Assets: □\$3,001 -\$6,000 (I	(N)			
Status: GOAH TRNE (check one)				ligibility	ibility Code: INC. Provider ID #:Worker ID #:						#:		
Primary source of heating home: Electric Gas Fuel Oil the household? Wood Kerosene Yes No Enter on CICLIENT Screen Enter on CICLIENT			the			here a child 5 years old or younger in household? Yes			rs who meet the hip/alien status				
*****ALL INFORMATION LISTED ABOVE MUST BE ENTERED INTO CIRTS****													
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 Type Income* Annual Income To Applicant 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. 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: □CSBG □Weatherization □Food Stamps 6. Have you or any member of your household received energy assistance within the last 13 months? □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: City/State/Zip: County: 10. What is the primary source of energy you use to HEAT your home? Choose one and provide the information below:													
. □Electric □Natural (Company Name	Gas □ Propane		□Fuel Oil Customer Na	□Wood me on A	ccount		□Other	- spe Cu	ecify istomer Account #	#	Comp	pany's Telephone #	
11. What is the primary source of energy you use to COOL your home? Choose one and provide the information below: Air Conditioning Fans													
Company Name			Customer Na	nformation about your election on Account			ectric con	ctric company: Customer Account #			Company's Telephone #		
Please carefully read th The information above lowest income and grea	is, to the best of my kno	owled	ge, true and com	plete. I un	idersta sabled,	nd that pri medical ne	ority in pr edy or chi	ovid	ing assistance will h	oe given t	to those	households with the make benefit payments	

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****

	urces and amounts of all earned and unearned inco	Annual income limit (150% poverty) by household size:
Gross Earned Income: Source: Income per month	Gross Unearned Income: Source: Income per mo	
\$		1\$14,355
\$		2\$19,245 3\$24,135
		4\$29.025
 \$		— 5\$33,915
<u> </u>	\$	6\$38,805 7\$43,695
2. Show calculations below:	Medicare Premium \$ (If not included in SSA above - \$78.20)	0 0 0 505
Total Gross Earned Income:	\$	(Add \$4,890 for each additional
Total Gross Unearned Income:	\$	member of family units with more than 8 members.)
Total Gross Income:	\$	
Total Gross Annualized Income: \$/month x 12 months	\$	
Number of persons in Household:		
Annual Income Limit:		
	Yes □ No IF HOUSEHOLD INCOME IS LESS THAN AND HOME UTILITIES ARE PURCHASED:	AN \$738 A YEAR, EXPLAIN HOW FOOD,
4. Date verified household has not received	DCA LIHEAP Crisis Benefits: Contact Person:	Date:
	ot an eligible crisis, deny. Verify the benefit will rese made, deny. This section must be completed.	olve the crisis. If the maximum will not resolve the
c. Does the 18 hour or the 48 hour rule apple.d. Will the EHEAP benefit resolve the crisis6. If the household is still eligible, call the vespace below):		cord below (explain different amount paid in the
·	imum Amount: Contact Person:	
	ehold member? □Yes □No If no, explain:	
c. Provide the following information about the		
Company Name Customer Name		ervice/Product* Amount Paid from
on Account	Account. # Telephone #	EHEAP
	nel oil, wood, blanket, fan, repair to heating system, rep	
	be met:	
7. Resolution of Energy Emergency: a. Case Approved (check one) ☐ Yes	□No Date:	
PLACE COPY OF APPROPRIATE NOTIO	CE IN THE APPLICANT S FILE.	
b. Date of resolution:	Time of Resolution:	Extension Date:
c. Was the 18/48 hour rule met?	es □No	
d. Written notification sent?	s □No	
8. Denial of Assistance: If energy assistance was denied, explain:		
have determined the eligibility of the application	ant. I am not the applicant, nor am I a friend, relati	ve or employee of the applicant.
Caseworker's Signature:	Date:	Agency:
Application must be reviewed for mistakes a	and appropriate file documentation prior to paymen	t:
Supervisor/Edit Staff Signature:		Date: