

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

Heating Season (March 2003) Cooling Season (April -September 2003) Heating Season (October 2003 - March 2004) **DATE STAMP:**

Name: (Household member 60 or over)		Medicaid Number:	Social Security Number/I.D.:			
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"/> Other (O) <input type="checkbox"/> Provider (P)		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, if CARES check if <input type="checkbox"/> Imminent Risk (IM) <input type="checkbox"/> APS,(A) , if APS, check level of risk <input type="checkbox"/> High (H) <input type="checkbox"/> Moderate (M) <input type="checkbox"/> Low (L) <input type="checkbox"/> Lead Agency(L) <input type="checkbox"/> Hospital(H) <input type="checkbox"/> Upstreaming/CARES (U) <input type="checkbox"/> Other <input type="checkbox"/> Self 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 *If married, the couple's monthly income and 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. Enter on CICLENT Screen		*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: GOAH <input type="checkbox"/> Yes <input type="checkbox"/> No TRNE <input type="checkbox"/> Yes <input type="checkbox"/> No		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 Enter on CICLENT Screen	Is there an individual with a disability in the household? <input type="checkbox"/> Yes <input type="checkbox"/> No Enter on CICLENT Screen	Is there a child 5 years old or younger in the household? <input type="checkbox"/> Yes <input type="checkbox"/> No Enter on CICLENT Screen	What is the total number of individuals in the household? _____ Enter on CICLENT Screen			
*****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 To Applicant SELF	Type Income*	Annual Income
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
*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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 Porch Indian Tribe? <input type="checkbox"/> Yes <input type="checkbox"/> No						
5. Check the programs you or anyone in your household are currently eligible for or are receiving assistance from: <input type="checkbox"/> CSBG <input type="checkbox"/> Weatherization <input type="checkbox"/> Food Stamps						
6. Have you or any member of your household received energy assistance within the last 13 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following: Name of Agency: _____ Type of assistance: <input type="checkbox"/> Crisis <input type="checkbox"/> Home energy <input type="checkbox"/> 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: <input type="checkbox"/> heating <input type="checkbox"/> cooling b. Need to repair: <input type="checkbox"/> heating system <input type="checkbox"/> cooling system c. Need to pay deposit to turn on utilities for: <input type="checkbox"/> cooling or <input type="checkbox"/> heating d. Need to purchase: <input type="checkbox"/> space heater <input type="checkbox"/> blanket <input type="checkbox"/> wood <input type="checkbox"/> fuel oil <input type="checkbox"/> other heating fuel <input type="checkbox"/> A/C <input type="checkbox"/> fan						
8. Is the cost of home energy included in your rent? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 your home? Choose one and provide the information below: <input type="checkbox"/> Electric <input type="checkbox"/> Natural Gas <input type="checkbox"/> Propane <input type="checkbox"/> Fuel Oil <input type="checkbox"/> Wood <input type="checkbox"/> Other - specify Company Name Customer Name on Account Customer Account # Company's Telephone #						
11. What is the primary source of energy you use to COOL your home? Choose one and provide the information below: <input type="checkbox"/> Air Conditioning <input type="checkbox"/> Fans Company Name Customer Name on Account Customer Account # Company's Telephone #						
12. If not given in questions 10 and 11, provide the following information about your electric company: _____						

Company Name	Customer Name on Account	Customer Account #	Company's Telephone #
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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 earned and unearned income:				Annual income limit (150% poverty) by household size: 1.....\$13,470 2.....\$18,180 3.....\$22,890 4.....\$27,600 5.....\$32,310 6.....\$37,020 7.....\$41,730 8.....\$46,440 (Add \$4,710 for each additional member of family units with more than 8 members.)
Gross Earned Income:	Gross Unearned Income:			
Source: _____	Income per month: \$ _____	Source: _____	Income per month: \$ _____	
_____	\$ _____	_____	\$ _____	
_____	\$ _____	_____	\$ _____	
_____ Medicare Premium \$ _____ _____ (If not included in SSA above - \$58.70)				
2. Show calculations below:				
Total Gross Earned Income:	\$ _____			
Total Gross Unearned Income:	\$ _____			
Total Gross Income:	\$ _____			
Total Gross Annualized Income:	\$ _____			
\$ _____/month x 12 months				
Number of persons in Household:	_____			
Annual Income Limit:	_____			

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. 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.

a. Is the household in a life-threatening situation? Yes No

b. Does the 18 hour or the 48 hour rule apply? 18 hr 48 hr

c. Is the applicant in a crisis situation? Yes No

d. Will the EHEAP benefit resolve the crisis situation? Yes No

6. If the household is still eligible, call the vendor to verify the minimum amount needed and record 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 \$300, explain how excess cost will be met: _____

7. Resolution of Energy Emergency:

a. Case Approved (check one) Yes No Date: _____

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

b. Date of resolution: _____ Time of Resolution: _____ Extension Date: _____

c. Was the 18/48 hour rule met? Yes No

d. Written notification sent? Yes No

8. 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 Signature: _____ Date: _____ Agency: _____

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

Supervisor/Edit Staff Signature: _____ Date: _____