

**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/I.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)		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)				
ETHNICITY: <input type="checkbox"/> Hispanic (H) <input type="checkbox"/> O - Other (O)		If at Imminent Risk of NH placement, check: <input type="checkbox"/> Imminent Risk (IM)				
Primary Language: _____		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 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. (PSA 1 ONLY) Are you or is anyone in your household a member of the Poarch Indian Tribe? <input type="checkbox"/> Yes <input type="checkbox"/> No						
5. Check the programs you / anyone in your household are currently eligible for /are receiving assistance from: <input type="checkbox"/> Food Stamps <input type="checkbox"/> Community Services Block Grant (CSBG) <input type="checkbox"/> Weatherization Assistance Program (WAP) <input type="checkbox"/> None of these						
6. Have you or any member of your household received energy assistance in the current season? <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/COOL your home during the season for which you are applying? 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"/> Air Conditioning <input type="checkbox"/> Fans <input type="checkbox"/> 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:

Gross Earned Income Source	Income per month:	<u>Consumer automatically qualifies for EHEAP if:</u>	
_____	\$ _____	Consumer has a home energy emergency, <u>AND</u>	1.....\$15,600
_____	\$ _____	Receives Food Stamps, or	2.....\$21,000
_____	\$ _____	Applied for Weatherization Assistance Program and is currently eligible, or	3.....\$26,400
Gross Unearned Income Source:	Income per month:	Applied for Community Services Block Grant and is currently eligible	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.)

TOTAL \$ _____

2. Show calculations below:

Total Gross Monthly Earned Income:	\$ _____		
Total Gross Monthly Unearned Income: +	\$ _____	Add in Medicare Premium if not included in SSA above (\$96.40). Also add in amount for Medicare Part D, if applicable	Annual Income Limit: \$ _____
Add Medicare Premium and/or Part D +	\$ _____		
Total Gross Monthly Income:	= \$ _____	(monthly x 12 = annual)	*Poverty Guidelines effective 1/23/2008
Total Gross Annualized Income:	\$ _____		

Number of persons in household: _____

3. Income is at or below the income limit? Yes 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 is a homeowner? Yes No

a. If yes, and the applicant 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 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?	Yes	No	
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. \$ _____ EHEAP Benefit Amount
 - \$ _____ Deduct the Section 8 or public housing utility allowance deduction (Deduct the amount of the allowance for the period covered by the delinquent utility bill, from the total benefit amount, or indicate N/A)
 + \$ _____ Total EHEAP Benefit Amount (see 6d above)

d. Provide the following information about the benefit(s) provided:

Company Name	Customer Name On Account	Customer Account #	Company's Telephone #	Service/Product*	<u>Amount Paid from EHEAP minus Subsidy/Allowance</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

*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) 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: _____

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

Supervisor/Edit Staff Name (Print) _____ Signature: _____

Date: _____ Agency: _____