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

☐ Heating Season (March 2004) ☐ Cooling Season (April -September 2004) ☐ Heating Season (October 2004 - March 2005) **DATE 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: ☐ Home (CH) ☐ Other (O) ☐ Provider (P)	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.
Enter on CICLIENT Screen

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: ☐ Electric ☐ Gas ☐Fuel Oil ☐ Wood ☐ Kerosene Enter on CICLIENT Screen	Is there an individual with a disability in the household? ☐ Yes ☐ No Enter on CICLIENT Screen	Is there a child 5 years old or younger in the household? ☐ Yes ☐ No Enter on CICLIENT Screen	Number of household members who meet the citizenship/alien status requirements ___________

********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	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. 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:** ______________
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:
. Electric Natural Gas Propane Fuel Oil Wood 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: Air Conditioning 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 #

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 earned and unearned income:

Gross Earned Income:

Source:	Income per month:
________________	$ ______________
________________	$ ______________
________________	$ ______________
________________	$ ______________

Gross Unearned Income:

Source:	Income per month:
________________	$ ___________
________________	$ ___________
________________	$ ___________
________________	$ ___________
Medicare Premium (If not included in SSA above - $66.60)	$ ___________

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: ________________

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

1..................$13,965
2..................$18,735
3..................$23,505
4..................$28,275
5..................$33,045
6..................$37,815
7..................$42,585
8..................$47,355

(Add $4,770 for each additional member of family units with more than 8 members.)

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:** ___________________________

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