

**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:
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) 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)			
Primary Language: _____		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.)**

Gross Earned Income Source Income per month:
 _____ \$ _____
 _____ \$ _____
 _____ \$ _____

Gross Unearned Income Source: Income per month:
 _____ \$ _____
 _____ \$ _____
 _____ \$ _____
 _____ \$ _____

TOTAL \$ _____

Consumer automatically qualifies for E HEAP if:
Consumer has a home energy emergency, AND
Receives Food Stamps, or
Applied for Weatherization Assistance Program and is currently eligible, or
Applied for Community Services Block Grant and is currently eligible

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.)

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: = \$ _____
 Total Gross Annualized Income: \$ _____

Add in Medicare Premium if not included in SSA above (\$96.40). Also add in amount for Medicare Part D, if applicable

(monthly x 12 = annual)

Number of persons in household: _____

Annual Income Limit:
 \$ _____

*Poverty Guidelines effective
 1/23/2008

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 a homeowner? Yes No

a. If yes, and the applicant and has received more than three LIHEAP or E HEAP 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	c. Does the 18 hour or the 48 hour rule apply? Yes No
b. Is the household in a life-threatening situation? Yes No (if yes, 18 hr. applies in next question)	d. Will the E HEAP 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. \$ _____ E HEAP Benefit Amount
 - \$ _____ Deduct the Section 8 or public housing utility allowance deduction
 +\$ _____ Total E HEAP 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)

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

Company Name	Customer Name On Account	Customer Account #	Company's Telephone #	Service/Product* from E HEAP 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) 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: _____

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: _____