

Emergency Home Energy Assistance for the Elderly Program - Application

Section One: Applicant (Aged 60 and older) Information

Name: (First, M, Last)		<input type="checkbox"/> E HEAP <input type="checkbox"/> Heating Season <input type="checkbox"/> Cooling Season <input type="checkbox"/> E HEAP CARES <input type="checkbox"/> E HEAP ARP	
Date of birth:	Age:	SSN:	
Service address:			
City:		Florida County:	ZIP Code:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Number of people in the household:	Phone:
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other			
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other		Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	
Does the client have limited ability reading, writing, speaking, or understanding the English language? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is the client a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was the client referred to the local Veteran's Affairs office? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Applicant's income type(s):		Applicant's monthly income amount:	

Date Stamp

Intake worker's name:

Phone:

Section Two: Additional Household Members Information

Name:	Income type(s):		
	Age:	SSN:	Monthly income amount:
Name:	Income type(s):		
	Age:	SSN:	Monthly income amount:
Name:	Income type(s):		
	Age:	SSN:	Monthly income amount:
Name:	Income type(s):		
	Age:	SSN:	Monthly income amount:

Section Three: Household Characteristics

Is there a child 5 years of age or younger in the household? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, select all that apply: <input type="checkbox"/> 0-2 years old <input type="checkbox"/> 3-5 years old
Is there an individual with a disability in the household? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the applicant a U.S. citizen or an alien lawfully admitted for permanent residence? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the applicant a homeowner? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the applicant live in government subsidized housing, such as Section 8? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide the complex name: _____
If yes, does the household receive an energy subsidy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the applicant live in a student dormitory, adult family care home, or any kind of group living facility? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide the facility name: _____

Section Four: Heating and Cooling Information

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, provide the name of the Agency: _____
Type of Assistance: <input type="checkbox"/> Crisis <input type="checkbox"/> Home Energy <input type="checkbox"/> Weather-Related Date: _____
What is the primary source of home heating? (select one) <input type="checkbox"/> Electricity <input type="checkbox"/> Natural Gas <input type="checkbox"/> Propane <input type="checkbox"/> Wood/Coal <input type="checkbox"/> Refillable Fuels
Does the household use supplemental heating source? <input type="checkbox"/> Electricity <input type="checkbox"/> Wood/Coal <input type="checkbox"/> N/A
Air conditioning unit type? <input type="checkbox"/> Central A/C <input type="checkbox"/> Window/Wall A/C <input type="checkbox"/> Fans <input type="checkbox"/> Other – specify (including evaporative cooler)

Section Five: Energy Crisis Explanation

Client Attestation and Signature

<input type="checkbox"/> Home cooling or heating energy source has been disconnected. <i>(Life-Threatening)</i>	<p>The information provided on this application 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, medically 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 to determine my eligibility, if I am applying for crisis assistance, the agency has 18 hours to act upon my application with an eligible action. 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 appeal the decision. (If you sign with an "X" two witnesses are required.)</p>
<input type="checkbox"/> Unable to get delivery of fuel, is out of fuel, or is in danger of being out of fuel for heating. <i>(Life-Threatening)</i>	
<input type="checkbox"/> Other problems with lack of cooling or heating in the home, such as needing to pay a deposit, repair equipment, or interim emergency measure to avoid further crisis. <i>(Life-Threatening)</i>	
<input type="checkbox"/> Received a notice that the energy source for cooling or heating is going to be disconnected. <i>(Standard)</i>	
<input type="checkbox"/> Received a notice indicating the energy source bill is delinquent or past due. <i>(Standard)</i>	
<input type="checkbox"/> Has an energy source bill for which the due date has lapsed. <i>(Standard)</i>	

Client Signature: _____

Date: _____

ALL CLIENTS SHOULD SIGN THE WAIVER, AUTHORIZING THE RELEASE OF GENERAL AND/OR CONFIDENTIAL INFORMATION FOR LIHEAP/EHEAP FEDERAL REPORTING.

*Your Social Security Number (SSN) is confidential under law. We may not collect your SSN unless we explain the reason for collecting your SSN in writing and provide the applicable statutory authority for doing so. Certain provisions of Chapter 430, Florida Statutes, read with Section 119.071(5), Florida Statutes, specifically authorize the Department of Elder Affairs (DOEA) and its designated staff/employees to collect SSNs when authorized by law or when collection of SSNs is imperative to the performance of DOEA's statutorily assigned duties. The Department is collecting your social security number as part of its responsibility to provide Emergency Home Energy Assistance.

Emergency Home Energy Assistance for the Elderly Program - Eligibility Worksheet

Section Six: Income Eligibility Determination

Annualize all household income.	Staple calculator tape here showing income calculations, or write calculations in this space.	Poverty Guidelines effective 07/01/2021.	
1. Add all gross monthly earned and unearned income from the past 30 days of all household members.		Select the annual income limit by household size:	
2. Add Medicare Premium (\$148.50), if not included in SSA amount.		<u>150% of Poverty</u>	<u>50% of Poverty</u>
3. Add Medicare Part D, if applicable.		<input type="checkbox"/> 1.....\$19,320	\$ 6,440
4. To annualize, multiply the monthly total by 12 months.		<input type="checkbox"/> 2.....\$26,130	\$ 8,710
Annual Household Income \$ _____		<input type="checkbox"/> 3.....\$32,940	\$10,980
		<input type="checkbox"/> 4.....\$39,750	\$13,250
		<input type="checkbox"/> 5.....\$46,560	\$15,520
		<input type="checkbox"/> 6.....\$53,370	\$17,790
		<input type="checkbox"/> 7.....\$60,180	\$20,060
		<input type="checkbox"/> 8.....\$66,990	\$22,330
		(Add \$6,810 for each additional member of family unit with more than 8 members.)	

Categorically Eligible If the total annual household income is less than 50% of the current Federal Poverty Guidelines for household size (using chart above), and no one in the household is receiving SNAP assistance, the applicant must provide a signed statement of how basic living expenses (i.e., food, shelter, and transportation) are provided for the household.

Section Seven: Vendor, Benefit, and Verification Information

Energy Vendor #1		Other Vendor #1		Contact made with LIHEAP provider to verify previous crisis assistance. Contact Person: _____ Date of contact: _____ Has the applicant received LIHEAP crisis assistance during the current season? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____		Name: _____		
Account Number: _____		Account/Voucher Number: _____	Date: _____	
Minimum Amount Due: _____		Amount Due: _____		
Verification and Commitment Contact Person: _____ Date: _____		<input type="checkbox"/> Blanket <input type="checkbox"/> Repair Existing Heating or Cooling Equipment <input type="checkbox"/> Portable Fan <input type="checkbox"/> Emergency Shelter <input type="checkbox"/> Space Heater <input type="checkbox"/> Other <input type="checkbox"/> Window A/C		If the minimum amount due is more than the past due amount, did the energy vendor verify that this amount is required? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Energy Vendor #2		Other Vendor #2		
Name: _____		Name: _____		
Account Number: _____		Account/Voucher Number: _____	Date: _____	
Minimum Amount Due: _____		Amount Due: _____		
Verification and Commitment Contact Person: _____ Date: _____		<input type="checkbox"/> Blanket <input type="checkbox"/> Repair Existing Heating or Cooling Equipment <input type="checkbox"/> Portable Fan <input type="checkbox"/> Emergency Shelter <input type="checkbox"/> Space Heater <input type="checkbox"/> Other <input type="checkbox"/> Window A/C		If the minimum amount due to resolve the crisis is more than the maximum allowed, explain how the balance of the amount due will be paid if approved for EHEAP crisis assistance. _____ _____ _____
(1) Total Energy Vendors	\$ _____	(4) Total Other Vendors	\$ _____	Is the name on the fuel bill that of the applicants? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide name on bill: _____
(2) Energy Subsidy	\$ _____	Total EHEAP Benefit Add Total Energy Vendor (4) & Total Other Vendor (4)		
(3) Water, Sewer, Garbage, Fire, etc.	\$ _____			
(4) Deduct (2&3) from (1)	\$ _____			

Section Eight: Weatherization Assistance Program (WAP) Referral

If the applicant is a homeowner, has he/she received more than three LIHEAP or EHEAP benefits in the last 18 months?

Yes No N/A

If the answer to the previous question is "yes," was the applicant referred to WAP? Yes No N/A

If the answer to the last question is "no," explain: _____

Section Nine: Resolution of Crisis

Resolution of the Heating/Cooling Energy Crisis occurred within 18/48 hours, by the following eligible action(s): (Select all that apply)			
<input type="checkbox"/> Approval of application		<input type="checkbox"/> EHEAP benefit prevented disconnection	
<input type="checkbox"/> Commitment made to vendor		<input type="checkbox"/> EHEAP benefit restored energy already disconnected	
<input type="checkbox"/> Denial of Application, pending additional information		<input type="checkbox"/> Yes, client signed waiver	
<input type="checkbox"/> Denial of Application, ineligible		<input type="checkbox"/> No, client refused to sign waiver	
<input type="checkbox"/> Written referral and assistance to access other community resources			

Case Worker Signature

I have determined the eligibility of the applicant. I am not the applicant, nor am I a friend, relative, or employee of the applicant.

Approval Signature

The application and eligibility determination must be reviewed for errors and appropriate file documentation prior to making payment. I have reviewed and approved this application for crisis assistance.

Case Worker's Name: _____	Supervisor/Peer's Name: _____
Case Worker's Signature: _____	Supervisor/Peer's Signature: _____
Date: _____	Date: _____
Agency Name: _____	Agency Name: _____