

BREVARD COUNTY LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP) APPLICATION

1. Give the following information for the applicant first, then for each person living in your home. If more than seven people are living in your home, list the additional people on a separate piece of paper, giving the same information and attach it to this form. **(Please print neatly and do not fax application.)**

[illegible]

****Source of Income: wages, self-employment, social security, child support, regular gifts, unemployment compensation, retirement benefits, SSI, TANF/WAGES, pensions, and interest on savings, etc.**

2. If your annual household income is less than 50% of the poverty guidelines, **explain how you pay for food, shelter, clothing, transportation, and home utilities.**

3. Are you: Renting (apartment or home) OR own/purchasing your home?

4. How many disabled persons live in the household?

5. If you share your living or mailing address with others who are not part of your household, list their names:

_____;

6. If you, or anyone in your home, are not a U.S. citizen or an alien lawfully admitted for permanent residence, give the person's name and alien status under the Immigration and Naturalization Act.

Name:

Alien Status:

Name:

Alien Status:

7. Are you, or any member of your household, a member of the Porch Creek Indian Tribe?

☐ YES☐ NO

FOR OFFICE USE ONLY

DATE STAMP

- ☐ Home Energy
- ☐ Summer Crisis
- ☐ Winter Crisis
- ☐ Weather Related
- ☐ Restored Electric/Gas after disconnection
- ☐ Coronavirus (COVID-19) Assistance

REVISÉD JUNE 2020

8. Does anyone in your household have any Health Insurance? ☐ YES ☐ NO
(If Yes, please check which one) ☐ Private ☐ Medicaid ☐ Medicare ☐ Healthy Kids
☐ Stay Well ☐ Kid Care ☐ Other

9. The address where you are living:

_____, Florida
Address City Zip County

10. Your mailing address, if different from above:

_____, Florida
Address City Zip County

11. Day time telephone number where you can be reached:

12. Check the programs that anyone in your household is currently eligible for or receiving assistance from:

- ☐ Community Services Block Grant
☐ Weatherization
☐ SNAP

13. If you, or any member of your household, have received Low Income Home Energy Assistance Program (LIHEAP) or Emergency Home Energy Assistance for the Elderly Program (EHEAP) in the last 13 months, complete the information below: **FOR OFFICE USE ONLY**

Name of Agency Type of help Date

Name of Agency Type of help Date

Verified by Staff:

14. Do any of the following situations currently apply to you? (Check the appropriate box below.)

- ☐ My electric/gas has been disconnected. ☐ I have little or no propane, fuel oil or wood for heat.
☐ My current electric bill is delinquent. ☐ I have a shut-off notice from my gas company.
☐ My current natural gas bill is delinquent. ☐ I have a shut-off notice from my electric company.
☐ None of the above currently apply to my household.
☐ Other energy crisis – please describe

15. If your cost of home energy is included in your rent, give the name and telephone number of your landlord. Attach a copy of a letter from the landlord confirming that your rent includes utilities.

Landlord:

Landlord Telephone No.:

16. If you live in a government subsidized housing complex, Section 8 housing, dormitory, nursing home, adult foster home, or any kind of group living facility, complete the following:

Name of the place where you live:

_____, Florida
Address City Zip County

17. Provide the following information about the primary source of energy you use to **heat** your home. Give only one company.

Energy Source	Company's Name	Customer's Name on the Account	Customer's Account Number	Company's Telephone #
Electric				
Natural Gas				
Propane				
Fuel Oil				
Wood				
Other – Specify:				

18. Provide the following information about the primary source of energy you use to **cool** your home.

Energy Source	Company's Name	Customer's Name on the Account	Customer's Account Number	Company's Telephone #
Air Conditioning				
Fans				

19. If not given above in questions 17 or 18, please provide the following information about your electric company.

Company's Name	Customer's Name on the Account	Customer's Account Number	Company's Telephone #

20. **Attach a copy of your current bills for all companies listed above in questions 17, 18, and 19.**

FRAUD STATEMENT: 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, medically needy or where 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 18 hours to approve or deny my application; and, if I am applying for Home Energy Assistance, the Agency has 15 days 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.

APPLICANT'S SIGNATURE

DATE

ELIGIBILITY SPECIALIST

DATE

SUPERVISOR/EDIT STAFF

DATE



BOARD OF COUNTY COMMISSIONERS

Housing and Human Services

Community Action Agency
Dr. Joe Lee Smith Community Center
415 Stone Street
Cocoa, Florida 32922

NOTICE REGARDING COLLECTION OF SOCIAL SECURITY NUMBERS LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

The following disclosure is being made pursuant to Section 119.071(5), Florida Statutes.

Social Security numbers of applicants and household members are requested because this information has been determined to be imperative for the performance of the duties and responsibilities prescribed by law under the Low Income Home Energy Assistance Program. This information is not required by state or federal law; however, Social Security numbers are necessary to determine eligibility for program services and specifically for the following purposes:

1. To verify an applicant's identity.
2. To verify household size.
3. To verify household income.

A Social Security number collected pursuant to this notice can only be used by the Florida Department of Economic Opportunity and the Brevard County Housing and Human Services/Community Action Agency for the purposes specified above.

Nondisclosure except under limited circumstances. Social Security numbers will not be disclosed to others unless required or authorized by Florida Law. Section 119.071(5), Florida Statutes, allows disclosure of a person's Social Security number under the following specific, limited circumstances:

- If disclosure is expressly required by federal or Florida Law or is necessary for the agency or governmental entity to perform its duties and responsibilities;
- If the individual expressly consents to disclosure in writing;
- If disclosure is made to prevent and combat terrorism pursuant to the U.S. Patriot Act of 2001 or Presidential Executive Order 13224 (blocking property and prohibiting business transactions with persons who commit, threaten to commit, or support terrorism);
- For an agency employee and dependents, if disclosure is necessary to administer the person's health benefits or pension plan funds; or
- If disclosure is for the purpose of the administration of the Uniform Commercial Code by the office of the Secretary of State.
- If disclosure is requested by a commercial entity for permissible uses under the federal Driver's Privacy Protection Act of 1994, the federal Fair Credit Reporting Act, or the federal Financial Services Modernization Act of 1999 (for example, to verify the accuracy of personal information provided by the individual to the commercial entity; use by an insurer in connection with claims investigation or anti-fraud activities; for use in connection with a credit transaction.)

Acknowledgment of Receipt of Notice

I confirm that I have been provided a copy of this notice regarding the collection of my Social Security number and the Social Security numbers of all household occupants as part of the application process for the Low Income Home Energy Assistance Program.

Applicant's Signature

Date



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Housing and Human Services

Community Action Agency
Dr. Joe Lee Smith Community Center
415 Stone Street
Cocoa, Florida 32922

BREVARD INFORMATION COLLABORATIVE (B.I.C.) PROJECT CLIENT RELEASE
(This form must be completed by every Adult Household Member)

I understand and acknowledge that this agency is a member of the Brevard Information Collaborative Project (hereafter referred to as B.I.C.), and I consent to and authorize the collection of data and information maintained by this agency to B.I.C. and affiliated agencies, provided such agency is a party to the B.I.C. agency agreement under which the agency has specifically agreed to share information. These agencies include, but are not necessarily limited to participants in the Homeless Management Information Systems (HMIS) grant, and the United Way Outcome Measures Pilot Project. The data, information and records gathered and prepared by the Agency and B.I.C. will be included in the database and may be utilized by B.I.C. and affiliated agencies to: a) provide individual case management; b) produce reports regarding utilization of services; c) track individual program outcomes; d) provide accountability for individuals and entities that provide funds for use in providing services in Brevard County; e) identify unfilled service needs and plan for the provision of new services; f) allocate resources among agencies engaged in the provision of services in Brevard County and g) be used for all other uses to be deemed appropriate by B.I.C. I understand and acknowledge that my data and information may be used in aggregate data along with information off other individuals served by the Agency for the purposes described above, I understand and acknowledge that data, information and records pertaining to the services provided to me by the Agency will only be disclosed to agencies, individuals and entities other than B.I.C. only with my written authorization.

I understand and acknowledge that the data pertaining to the services provided to me may include medical/health information and other information, the privacy of which may be protected by Federal or Florida State Laws and expressly consent to the release of such information in accordance with these protections.

I understand and acknowledge that I have the right a) to inspect, copy, and request amendment of all records maintained by the Agency related to the provision of services and to receive a paper copy of this form; and b) to file a grievance if I believe my privacy rights have been violated. This grievance must be submitted to the Brevard County Community Action Agency Supervisor at the Dr. Joe Lee Community Center, 415 Stone Street, Cocoa, Florida 32922 and such grievance will be responded to in accordance with the B.I.C. Policies and Procedures manual.

I understand and acknowledge that I have the right to opt out of having my data information and records disclosed to B.I.C. and affiliated agencies by providing notice to the Agency and that I am entitled to services regardless of my decision. I further understand and acknowledge that I may revoke this consent at any time by providing written notice to the Agency.

Client Name: _____

Agency Name: _____

Client Signature: _____

Date: _____