Tri-County Community Council, Inc
PO Box 1210
Bonifay, Florida 32425

****CURRENT PICTURE ID FOR APPLICANT AND ALL HOUSEHOLD MEMBERS 18 AND OLDER, BIRTH CERTIFICATES FOR ALL HOUSEHOLD MEMBERS UNDER 18, SOCIAL SECURITY CARDS FOR ALL HOUSEHOLD MEMBERS, HOUSEHOLD INCOME FOR ALL HOUSEHOLD MEMBER FOR LAST 30 DAYS (CANNOT USE BANK STATEMENTS TO SHOW INCOME).

LIHEAP ASSISTANCE APPLICATION

1. Give the following for the applicant first, then for each person living in your home. If more than seven 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.

FOR OFFICE USE ONLY

( ) HOME ENERGY DATE STAMP
( ) SUMMER CRISIS
( ) WINTER CRISIS
( ) WEATHER RELATED
( ) EHEAP (referred)
( ) WAP (referred)

Name (First, Middle, Last)	Social Security Number	Age Sex	Date of Birth M/D/Y	Relationship to Applicant	Source of Income*	Monthly Income
(Applicant's Name)						

*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.

FOR OFFICE USE ONLY - INFORMATION NEEDED TO COMPLETE APPLICATION

_____

2. If the total household income is less than 50% of the current Federal Poverty Income Guidelines and no one in the household is receiving SNAP (food stamps), please explain household maintenance. (How do they pay for housing, food, utilities, transportation, etc.)

_____

_____

_____

3. If a member of household is disabled/handicapped indicate number of members? _____

Date sent for Vendor notification_____

LIHEAP ASSISTANCE APPLICATION

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

_____ ; _____ ; _____ ; _____

5. The address where you are living:

_____ _____, FL _____ _____ _____
Street Number and Name, RFD, Apt. or Lot Number | City or Town | Zip Code | County

6. Your mailing address, if different from above:

_____ _____, FL _____ _____ _____
Street Number and Name, RFD, Apt. or Lot Number | City or Town | Zip Code | County

7. Day time telephone number where you can be reached: ( )_____

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

( ) CSBG ( ) Weatherization ( ) TANF/WAGES ( ) Food Stamps

( ) Lifeline and Link-up Florida (telephone)

9. If you or any member of your household has received energy assistance in the last 12 months, complete the information below:

_____ _____ _____ _____
Name of Agency | Type of help (elderly, crisis, emergency) | Date

(Verified last date Home Energy received _____)

10. **FOR OFFICE USE ONLY**

CRISIS ONLY CRISIS ASSISTANCE – VENDOR CONTACT – (RESOLUTION OF CRISIS) Explain: _____ _____	Yes IM _____ Rest_____ W _____	No _____ _____ _____

A.	Check agency records for prior LIHEAP assistance
B.	If someone in household is 60 years or older, contact local EHEAP provider to determine if crisis assistance has been provided for the current season (heating or cooling).
C.	Check records for prior EHEAP crisis assistance. Name of EHEAP Provider Contacted: _____ Date/Time: _____
D.	Resolution of Crisis:_____ Name of Vendor Contacted: _____ Date/Time: _____

WAP Referral (Community Action Program Committee, Inc.)
Name contacted: _____ Date contacted: _____

LIHEAP ASSISTANCE APPLICATION

11. 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: _____

12. If you or any member of your household is member of the Porch Creek Indian Tribe check Yes_____ ___

13. 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, list the name of the place: _____

    _____

14. Do you receive an energy subsidy _____ If yes, amount_____

15. **MAIN ENERGY SOURCE**
    Check which source is used for each need.

ENERGY NEED	ELECTRIC	GAS	OTHER-Describe
HEATING			
COOLING			
OTHER (cooking, water, etc.)			

16. Amount of utility bill $ _____

17. Is the name on the energy bill that of a household member? Yes_____No_____, If no, explain below:

    _____

    _____

18. Does a family member serve on Tri-County Community Council Board of Director's or is employed by Tri-County Community Council? Yes____No_____

FRAUD STATEMENT: The information above is, to the best of my knowledge, true and complete. I understand that if I have supplied any false information I can be denied and restricted from reapplying for 1 (one) year. I understand that priority in providing assistance will be given to applicant households with members who are elderly, disabled, or have children under the age of five. 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 appeal hearing. I hereby give permission to Tri-County Community Council, Inc. o obtain information from agencies and individuals to determine need and eligibility for assistance to release information to agencies and/or individuals in the course of providing assistance. This statement has been read and is understood.

_____ _____
APPLICANT SIGNATURE DATE

_____ _____ _____ _____
CASEWORKER DATE SUPERVISOR/EDIT STAFF DATE

Name of applicant_____

THE FOLLOWING INFORMATION MUST BE FURNISHED FOR ALL HOUSEHOLD MEMBERS

Education Levels	Number of Individuals	
	Ages 14-24	25+
Grades 0-8		
Grades 9-12/Non-Graduate		
High School Graduate/ Equivalency Diploma		
12 grade + Some Post-Secondary		
2 or 4 years College Graduate		
Graduate of other post-secondary school		
Unknown/not reported		

Disconnected Youth	Number of Individuals
Youth ages 14-24 who are neither working or in school	

Ethnicity/Race	Number of Individuals
Ethnicity	
Hispanic, Latino or Spanish Origins	
Not Hispanic, Latino or Spanish Origins	
Unknown/not reported	

Race	
American Indian or Alaska Native	
Asian	
Black or African American	
Native Hawaiian and Other Pacific Islander	
White	
Other	
Multi-race (two or more of the above)	
Unknown/not reported	

Work Status ***(Individuals 18+)***	Number of Individuals
Employed Full-Time	
Employed Part-Time	
Migrant Seasonal Farm Worker	
Unemployed (Short-Term, 6 months or less)	
Unemployed (Long-Term, more than 6 months)	
Unemployed (Not in Labor Force)	
Retired	
Unknown/not reported	

Military Status	Number of Individuals
Veteran	
Active Military	
Unknown/not reported	

Housing	
Own	
Rent	
Other	
Permanent Housing	
Homeless	
Other	
Unknown/not reported	

Health	Number of Individuals		
	Yes	No	Unknown
Disabled (declared)			
	Yes	No	Unknown
Health Insurance*			

Health Insurance Sources	
Medicaid	
Medicare	
State Children's Health Insurance Program	
State Health Insurance for Adults	
Military Health Care	
Direct-Purchase	
Employment Based	
Unknown/not reported	

Marital Status	
Married	
Divorced	
Separated	
Single	
Widowed	
Never Married	
N/A	

Name of Applicant_____

Non-Cash Benefits	*Check **ALL** that apply*
SNAP	
WIC	
LIHEAP	
Housing Choice Voucher	
Public Housing	
Permanent Supportive Housing	
HUD-VASH	
Childcare Voucher	
Affordable Care Act Subsidy	
Other	
Unknown/not reported	

Other Income Source	*Check **ALL** that apply*
TANF	
Supplemental Security Income (SSI)	
Social Security Disability Income (SSDI)	
VA Service-Connected Disability Compensation	
VA Non-Service Connected Disability Pension	
Private Disability Insurance	
Worker's Compensation	
Retirement Income from Social Security	
Pension	
Child Support	
Alimony or other Spousal Support	
Unemployment Insurance	
EITC	
Other	
Unknown/not reported	

FLORIDA DEPARTMENT of ECONOMIC OPPORTUNITY

Authorization for Release of General and/or Confidential Information For LIHEAP/EHEAP Federal Reporting

The Florida Department of Economic Opportunity's (DEO) Low Income Home Energy Assistance Program (LIHEAP)Program Office is requesting that you authorize your utility service provider to disclose the following information to the LIHEAP office to which you are applying for assistance:

- Your utility account status and history, such as payment history, past due amounts, deposits, current shut-off due dates or disconnection, current life support status, payment arrangements, and history of energy assistance payments.
- Your total annual energy usage and charges for up to twelve months.

The Florida LIHEAP office and its contractors will use this information todevelop LIHEAP program performance measures and meet Federal reporting requirements.

Please note that:

- You have a right to receive a copy of this form.
- You are not required to authorize your utility service provider to disclose your customer data.
- Your decision not to authorize the disclosure will not affect your utility services or any LIHEAP assistance you may be eligible for.
- Your utility service provider may not disclose your customer data unless you authorize the disclosure to the LIHEAP office, DEO, or as otherwise permitted or required by laws or regulations.
- Your utility service provider will have no control over the data disclosed pursuant to this consent, and will not be responsible for monitoring or taking any steps to ensure that the Florida LIHEAP office maintains the confidentiality of the data or uses the data as authorized by you.
- The Florida LIHEAP office will not disclose any private applicant information except for the purpose of administering public assistance as defined by State and Federal laws and regulations and developing LIHEAP program performance measures.

ACCOUNT HOLDER (CUSTOMER NAME):	
SERVICE ADDRESS FOR UTILITY:	
NAME OF UTILITY SERVICE PROVIDER:	
UTILITY ACCOUNT NUMBER:	
PHONE NUMBER FOR UTILITY ACCOUNT:	

SECTION A: APPLICANT READS AND COMPLETES THIS SECTION ONLY IF HE/SHE IS THE ACCOUNT HOLDER

I hereby authorize the above named utility and this agency to disclose pertinent information regarding my account to agencies that may provide me financial assistance, including the Florida LIHEAP Office. I understand that the purpose of this disclosure is solely for federal reporting purposes and does not determine my eligibility for assistance. I further understand that some of the information the above named utility may provide to this agency may be considered confidential. I also understand that the above named utility does not and will not have control over any account information provided to agencies pursuant to this Authorization, and I will hold the utility harmless for any claim related to the account information provided. All information is accurate to the best of my knowledge. The agency may verify information contained in the payment assistance application, including the utility account for which I am seeking assistance.

ACCOUNT HOLDER'S SIGNATURE: _____ **DATE:** _____

SECTION B: APPLICANT READS AND COMPLETES THIS SECTION ONLY IF HE/SHE **IS NOT THE ACCOUNT HOLDER**

As applicant for payment assistance for the above named utility account, I hereby confirm, under penalty of perjury, that I am an Authorized Representative on behalf of the AccountHolder and I have authority to initiate this assistance application on his/her behalf.This may be confirmed at the agency's discretion, by contacting the Account Holder.I, and the Account Holder, understand that the purpose of this disclosure is solely for federal reporting purposes and does not determine my eligibility. I further understand that some of the information the above named utility may provide to this agency may be considered confidential. I also understand that the above named utility does not and will not have control over any account information provided to agencies pursuant to this Authorization, and I will hold the utility harmless for any claim related to the account information provided. All information is accurate to the best of my knowledge. The agency may verify information contained in the payment assistance application, including the utility account for which I am seeking assistance.

APPLICANT'S NAME (NOT ACCOUNT HOLDER): _____

APPLICANT'S PHONE NUMBER: _____

APPLICANT'S SIGNATURE: _____ **DATE:** _____

SECTION C: FOR AGENCY USE ONLY

Agency must maintain this form in the Applicant's file and make it available to the utility vendor of record upon request, for accounting and auditing purposes.

AGENCY NAME: Tri-County Community Council, Inc.

PHONE: 850-547-4921

AGENCY CASEWORKER'S NAME: _____

AGENCY CASEWORKER'S SIGNATURE: _____

DATE: _____

NOITCE 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 Community Services Block Grant 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.

A social security number collected pursuant to this notice can only be used by the Florida Department of Economic Opportunity and Tri-County Community Council, Inc. (subgrantee) 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 Community Services Block Grant Program.

Date _____ Applicant's Signature _____

Authorization for Release of General and/or Confidential Information For FPL Payment Assistance Qualification

(Revised 10-2-2018)

Note: The Applicant must sign this form in order for the agency to use the Florida Power & Light (FPL) ASSIST process in qualifying the FPL account for payment assistance. Refusal to sign this form may lead to disqualification. The Applicant may appeal this requirement by speaking to the agency Director/Manager, as the agency deems appropriate. The agency Director/Manager may opt to contact FPL to discuss any confidentiality concerns the Applicant may have regarding the application/qualification process.

FPL ACCOUNT HOLDER (CUSTOMER NAME): _____

SERVICE ADDRESS FOR FPL (INCL. CITY/ST/ZIP): _____

FPL ACCOUNT NUMBER: _ _ _ _ _-_ _ _ _ _ **PHONE FOR FPL ACCOUNT:** _____

SECTION A: APPLICANT READS AND COMPLETES THIS SECTION ONLY IF HE/SHE **IS THE ACCOUNT HOLDER**

I hereby authorize FPL and this agency to disclose pertinent information to related community agencies. I understand that the need or purpose of this disclosure is solely to facilitate the assistance qualification process.

All information is accurate to the best of my knowledge. The agency may verify information contained in the payment assistance application, including the FPL account for which I am seeking assistance.

ACCOUNT HOLDER'S SIGNATURE: _____ **DATE:** _____

SECTION B: APPLICANT READS AND COMPLETES THIS SECTION ONLY IF HE/SHE **IS NOT THE ACCOUNT HOLDER**

As applicant for payment assistance for the above-referenced FPL account, I hereby confirm that I am not the Account Holder with FPL, but I am authorized by the Account Holder to initiate this assistance application on his/her behalf. This may be confirmed at the agency's discretion, by contacting the Account Holder.

All information is accurate to the best of my knowledge. The agency may verify my personal information contained in this authorization, including the FPL bill account for which I am seeking assistance.

APPLICANT'S NAME (NOT ACCOUNT HOLDER): _____

APPLICANT'S PHONE NUMBER: _____

APPLICANT'S SIGNATURE: _____ **DATE:** _____

SECTION C: FOR AGENCY USE ONLY

Agency must maintain this form in the applicant's file and make it available to FPL upon request, for accounting and auditing purposes.

AGENCY NAME : _____ **PHONE:** _____

AGENCY CASEWORKER'S NAME (*PLEASE PRINT*): _____

AGENCY CASEWORKER'S SIGNATURE: _____ **DATE:** _____