Emergency Home Energy Assistance for the Elderly Program (EHEAP)
Summary of Services for ages 60 and older

The EHEAP program provides heating/cooling (Electric) bill assistance. Payment is made to the energy vendor or landlord (if utilities are included with the rent) on behalf of the eligible household that meets income and residency criteria.

Home Energy Crisis Assistance is provided to an elder who is in immediate danger of losing home energy. Benefit payment amounts are determined based on a documented home energy crisis ***and*** eligibility guidelines:

- Elder (60+) must be experiencing a ***verifiable home energy crisis*** (see below). ***Note***: Payments can be for **PAST DUE** amounts only.
- Household income must be below 100% Max Income Value (MIV)
- St Johns County Resident
    - Cannot be a resident of a group living facility or a home where cost of residency is subsidized through a program administered by the state;
    - Cannot be a student living in a dormitory
- Complete the entire EHEAP Application and provide ***ALL required documentation***:
    - Drivers' License or State Issued ID (over 18); Birth Certificate or School ID (under 18)
    - Social Security Card (***Note***: must have actual card)
    - Bank Statement (Last 30 days)
    - Proof of all income (***Note***: Bank Statement cannot be used to verify income)
    - Past Due Energy Bill
    - Copy of lease to verify if a utility allowance is given

Emergency Home Energy Assistance for the Elderly Program - Application

Section One: Applicant (Aged 60 and older) Information

Name: (First, M, Last)		☐ EHEAP ☐ Heating Season ☐ Cooling Season	
Date of birth:	Age:	SSN:	
Service address:		City:	
Florida County:	Zip Code:	Phone:	
Gender: ☐ Male ☐ Female		Number of people in the household:	
Marital Status: ☐ Married ☐ Partnered ☐ Single ☐ Separated ☐ Divorced ☐ Widowed			

Date Stamp

Intake worker's name:

Phone:

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Other

Primary Language: ☐ English ☐ Spanish ☐ Other _____

Does client have limited ability reading, writing, speaking, or understanding the English language? ☐ Yes ☐ No

Is the client a veteran? ☐ Yes ☐ No

Was client referred to the local Veteran's Affairs office? ☐ Yes ☐ No ☐ N/A

Applicant's income type(s):

Applicant's monthly income amount:

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? ☐ Yes ☐ No

If Yes, select all that applies: ☐ 0-2 years old ☐ 3-5 years old

Is there an individual with a disability in the household? ☐ Yes ☐ No

Is the applicant a U.S. citizen or an alien lawfully admitted for permanent residence? ☐ Yes ☐ No

Is the applicant a homeowner? ☐ Yes ☐ No

Does applicant live in government subsidized housing, such as Section 8? ☐ Yes ☐ No

If yes, provide the complex name: _____

If yes, does the household receive an energy subsidy? ☐ Yes ☐ No

Does applicant live in a student dormitory, adult family care home, or any kind of group living facility? ☐ Yes ☐ 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? ☐ Yes ☐ No

If yes, provide the name of Agency: _____

Type of Assistance: ☐ Crisis ☐ Home Energy ☐ Weather-Related Date: _____

What is the primary source of home heating? (select one) ☐ Electricity ☐ Natural Gas ☐ Propane ☐ Wood/Coal ☐ Refillable Fuels

Does household use supplemental heating source? ☐ Electricity ☐ Wood/Coal ☐ N/A

Air conditioning unit type? ☐ Central A/C ☐ Window/Wall A/C ☐ Fans ☐ Other – specify (including evaporative cooler)

Section Five: Energy Crisis Explanation

☐ Home cooling or heating energy source has been disconnected. *(Life-Threatening)*

☐ Unable to get delivery of fuel, is out of fuel, or is in danger of being out of fuel for heating. *(Life-Threatening)*

☐ Other problems with lack of cooling or heating in the home, such as needing to pay a deposit, repair of equipment, or interim emergency measure to avoid further crisis. *(Life-Threatening)*

☐ Notified that the energy source for cooling or heating is going to be disconnected. *(Standard)*

☐ Received a notice indicating the energy source bill is delinquent or past due. *(Standard)*

☐ Has an energy source bill for which the due date has lapsed. *(Standard)*

Client Attestation and Signature

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.)

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.

1. Add all gross monthly earned and unearned income from the past 30 days of all household members.
2. Add Medicare Premium ($185.00), if not included in SSA amount.
3. Add Medicare Part D, if applicable.
4. To annualize, multiply the monthly total by 12 months.

Annual Household Income

$_____

Staple calculator tape here showing income calculations or write calculations in this space.

State Median Income (SMI) Guidelines effective 07/01/2024.

Select the annual income limit by household size:

100% of Max Income Value (MIV)	50% of MIV
☐ 1.....$30,588	$ 15,294
☐ 2.....$40,000	$ 20,000
☐ 3.....$49,411	$ 24,706
☐ 4.....$58,823	$ 29,411
☐ 5.....$68,234	$ 34,117
☐ 6.....$77,646	$ 38,823
☐ 7.....$79,411	$ 39,705
☐ 8.....$81,175	$ 40,588

(Please refer to the Federal Poverty Guidelines (FPG) Benefits Matrix for income ranges for households with 9-or-more individuals.)

☐ Categorically Eligible

If the total annual household income is less than 50% of the current State Median Income 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
Name:

Account Number:

Minimum Amount Due:_____

Verification and Commitment

Contact Person: _____
Date:_____

Other Vendor #1
Name:

Account/Voucher Number:

Date:

Amount Due:_____

☐ Blanket
☐ Portable Fan
☐ Space Heater
☐ Window A/C
☐ Repair Existing Heating or Cooling Equipment
☐ Emergency Shelter
☐ Other

Energy Vendor #2
Name:

Account Number:

Minimum Amount Due:_____

Verification and Commitment

Contact Person: _____
Date:_____

Other Vendor #2
Name:

Account/Voucher Number:

Date:

Amount Due:_____

☐ Blanket
☐ Portable Fan
☐ Space Heater
☐ Window A/C
☐ Repair Existing Heating or Cooling Equipment
☐ Emergency Shelter
☐ Other

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?

☐ Yes ☐ No

If the minimum amount due is more than the past due amount, did the energy vendor verify that this amount is required?

☐ Yes ☐ No ☐ N/A

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	**$**	**(4) Total Other Vendors**	**$**
(2) Energy Subsidy	**$**	**Total EHEAP Benefit Add Total Energy Vendor (4) & Total Other Vendor (4)**	**$**
(3) Water, Sewer, Garbage, Fire, etc.	**$**		
(4) Deduct (2&3) from (1)	**$**		

Is the name on the fuel bill that of the applicants?

☐ Yes ☐ No

If no, provide name on bill:

_____

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)

☐ Approval of application	☐ EHEAP benefit prevented disconnection
☐ Commitment made to vendor	☐ EHEAP benefit restored energy already disconnected
☐ Denial of Application, pending additional information	☐ Yes, client signed waiver
☐ Denial of Application, ineligible	☐ No, client refused to sign waiver

☐ Written referral and assistance to access other community resources

Case Worker Signature	Approval 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.	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:

NOTICE REGARDING COLLECTION OF SOCIAL SECURITY NUMBERS
EMERGENCY HOME ENERGY ASSISTANCE FOR THE ELDERLY PROGRAM

Notice of Collection of Social Security Numbers

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 is crucial for the performance of the duties and responsibilities prescribed by law under the Low-Income Household 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 Commerce and SJC HHS-Social Services for the purposes specified above.

Nondisclosure except under limited circumstances

Social security numbers will not be disclosed to other entities 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 subrecipient 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 a subrecipient 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).

NOTICE REGARDING COLLECTION OF SOCIAL SECURITY NUMBERS
EMERGENCY HOME ENERGY ASSISTANCE FOR THE ELDERLY PROGRAM

FLORIDACOMMERCE

Notice of Collection of Social Security Numbers

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 is crucial for the performance of the duties and responsibilities prescribed by law under the Low-Income Household 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:

4. To verify an applicant's identity
5. To verify household size
6. To verify household income

A social security number collected pursuant to this notice, can only be used by the Florida Department of Commerce and SJC HHS-Social Services for the purposes specified above.

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- If disclosure is expressly required by Federal or Florida law or is necessary for the subrecipient 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 a subrecipient 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 Florida Low-Income Household Energy Assistance Program.

Signature of Applicant **Signature of Subrecipient Staff**

NOTICE REGARDING AUTHORIZATION FOR RELEASE OF GENERAL AND/OR CONFIDENTIAL INFORMATION FOR LIHEAP/EHEAP FEDERAL REPORTING

LIHEAP Authorization for Release of Information Form

The Florida Department of Commerce's (FloridaCommerce) Low-Income Household 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/EHEAP office and its contractors will use this information to develop LIHEAP/EHEAP 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, Florida Commerce, 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 ACCOUNTHOLDER**

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 Account Holder, 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: _____

PHONE:_____

AGENCY CASEWORKER'S NAME: _____

AGENCY CASEWORKER'S SIGNATURE:_____ DATE: _____

ACCESS - Partner View System Release

Customer's Name:_____ ACCESS Case/S.S.#_____

I,_____, understand that by my signature I am authorizing the Department of Children and Family (DCF) to release limited case information to_____ in their role as a DCF Community Partner and shall be used solely to fulfill obligation in assisting me with the application filed with DCF on_____. Information to be released is limited to:

- Verifying my eligibility information (approved, denied, enrolled or pending)
- Reason for closure or denial
- Assisting me with information on scheduled interview dates and time
- Assisting me with understanding what information is needed to complete my case and dates the information is due
- Assisting me with printing a temporary Medicaid card for eligible members in my household
- Assisting me with opening an account through My ACCESS Account

No additional information shall be provided to the Community Partner without my specific written consent. This authorization expires no more than ninety (90) days from the date signed.

Dated: _____day of _____, 20_____ Signature:_____

Printed Name:_____ Date of Birth:_____

Community Partner Staff Signature:_____

ACCESS - Liberación del Sistema de Visualización de Socios

Nombre del cliente:_____ ACCESS Caso/S.S.#_____

Yo,_____ , entiendo que con mi firma autorizo al Departamento de Niños y Familias (DCF) a divulgar información limitada del caso a_____ en su papel como Socio Comunitario de DCF y se utilizará únicamente para cumplir con la obligación de ayudarme con la solicitud presentada ante DCF el dia_____. La información que se divulgará se limita a:

- Verificar mi información de elegibilidad (aprobado, denegado, inscrito o pendiente)
- Motivo del cierre o negación
- Ayudarme con información sobre fechas y horas de entrevistas programadas
- Ayudarme a comprender qué información se necesita para completar mi caso y fechas de vencimiento
- Ayudarme a imprimir una tarjeta de Medicaid temporal para miembros elegibles en mi hogar
- Ayudarme a abrir una cuenta a través de Mi Cuenta ACCESS

No se proporcionará información adicional al Socio Comunitario sin mi consentimiento específico por escrito. Esta autorización vence no más de noventa (90) días a partir de la fecha firmada.

Fecha: Día_____ de_____ , 20_____ Firma:_____

Imprimir Nombre:_____ Fecha de Nacimiento:_____

Firma del personal del Socio Comunitario:_____

Care Connect Information Network
ServicePoint Consent
Release of Information (ROI)

Purpose of this form: St Johns County Social Services is a participating provider of vital services **("Participant")** who is an active project of the Care Connect Information Network (CCIN) hosted by St. Johns Care Connect, Inc. CCIN participating agencies work together to provide services to persons and families in need. When you request or receive services, we may collect data about you and your household such as:

- Your name, date of birth, Social Security Number, gender, ethnicity, race, veteran status, prior residence and program status.
- Your service needs, income, benefits, education, employment, destination, disability, general health, as well as pregnancy, HIV/AIDS, behavioral health, legal, and domestic violence status, destination.

How will my data be used? The ways in which the Agency may use or disclose your information are discussed in our Notice of Privacy Practices, which is posted in our reception area; we can direct you to the Notice at your convenience.

How will my data be protected? We enter your data in a computer program that is protected by passwords and encryption technology. Each Participant and CCIN user must sign an agreement to maintain the security and confidentiality of the information. Any person or Participant that violates the agreement may lose their access rights and be subject to further penalties.

How do I benefit by providing the requested information and sharing it with other agencies? By sharing your information with other agencies, you may be able to avoid being screened again, get services faster, and minimize how many times you have to tell your "story." You also help agencies document the need for services and demonstrate that funding is needed.

PLEASE PRINT NAME OF INDIVIDUAL *AFFECTED BY THIS ROI*: _____

IF HOUSEHOLD SITUATION, PLEASE INCLUDE HOUSEHOLD MEMBERS AFFECTED BY THIS ROI:

1.	2.	3.	4.
5.	6.	7.	8.

Client Informed Consent/Authorization for Release of Information - By signing this form, I agree that the Agency may disclose and other participating agencies in the SERVICEPOINT may use the following information for lawful purposes of the agencies that participate in the SERVICEPOINT and their employees and agents: (**please initial & check the applicable boxes if appropriate**)

____1) I agree to share ***all of my information and household member's information*** with other CCIN participating agencies.

____2) I agree to share all of my information with other CCIN participating agencies, ***WITH THE EXCEPTION OF***:
(Check All That Apply)

- □ HIV/AIDS Information, such as status, diagnostic test results, mode of transmission, sexuality
- □ Domestic Violence Information, such as abuse history, abuser information, trauma information
- □ Behavioral Health Information, such as substance and alcohol abuse and mental illness information

____3) I **DO NOT agree** to share any of my information with other CCIN participating agencies.

I UNDERSTAND THAT:

- I am not required to sign this consent and that if I refuse to sign this consent my treatment, payment, or eligibility for benefits will not be affected. I may also request a copy of this consent after I sign it.
- This consent form expires in seven (7) years. I have the right to revoke this consent at any time by writing to the Agency, except to the extent that the agency has acted in reliance on it. Past information I previously consented to release will not be retrieved from agencies that received that information. I understand that my revocation must be in writing.
- The Agency has posted a Notice of Privacy Practices, and I may request a paper copy of the Notice from the Agency. I acknowledge that I have been given an opportunity to read and/or request a copy of the Notice and that I have read the Notice. The Notice describes ways in which my personal information may be used and disclosed within and outside of the Agency. Its terms may change and I may obtain a copy of the Notice by writing to: CCIN SERVICEPOINT c/o St. Johns Care Connect, 400 Health park, Blvd. St. Augustine, FL 32086.
- I understand that neither the Agency, nor the CCIN, can control how another Participant will use or disclose my information that it receives under this consent. It is possible that the other agency will disclose my information to others, and that the disclosed information may no longer be protected by federal privacy regulations.

Signature of Individual or Guardian	Date	Signature of Witness	Date

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:** _____