

APPLICATION FOR CRISIS ASSISTANCE (Home Energy)



Black Hawk County Office
1535 Lafayette St, BOX 4120
Waterloo, IA 50704
(319) 291-2065

Buchanan County Office
1827 1st St. W., Ste. D
Independence, IA 50644
(319) 334-6081

Grundy Center Office
1606 G Avenue
Grundy Center, IA 50638
(319) 824-3460

Instructions: Complete this form and submit a copy of your Utility Bill and/or Disconnect Notice.
If you are NOT already LIHEAP approved, you will need to also complete a LIHEAP Application, which can be accessed online at www.operationthreshold.org or mailed to you.

Applicant Name: _____ Today's Date: _____
Address: _____ City: _____ Zip Code: _____
Phone: _____ Last 4 digits of SS #: _____ Email: _____
Do you Rent or Own? RENT OWN

HOUSEHOLD INFORMATION

Household Size: _____ HH Number of Members: Disabled: _____ 10/Under: _____ 60+ _____
Gross Monthly Income (Wages, SS, Child Support, etc.) of All Household Members: \$ _____

WHAT DO YOU NEED HELP WITH?

Energy Bill Furnace Not Working Fuel Delivery Disconnect Date: _____
Amount Due: \$ _____ Payment Due Date: _____ How much can you pay? \$ _____

WHERE ELSE HAVE YOU APPLIED FOR HELP WITH THIS BILL?

Agency : _____ Amount: \$ _____
Agency : _____ Amount: \$ _____

IS YOUR NEED FOR ASSISTANCE RELATED TO THE COVID-19 PANDEMIC? _____ Yes _____ No
HAVE YOU APPLIED FOR THE STATEWIDE RENT/UTILITY PROGRAM? _____ Yes _____ No

***Must include copy of most current utility bill or disconnect notice to process assistance.**

My signature below certifies that the above information is true and correct to the best of my knowledge.
I understand any false information may disqualify me for assistance.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

AGENCY USE ONLY

Application Status: Approved Denied Denial Reason: _____

Amount Paid by OT \$ _____ Agency/Vendor to Pay: _____

Client Account Name: _____ Client Account Number: _____

Return applications to crisis@operationthreshold.org, by Mail, or to the Drop Boxes located outside of each OT office.



BASIC INTAKE FORM

HEAD OF HOUSEHOLD CONTACT INFORMATION							
LAST NAME		FIRST NAME		MIDDLE INITIAL		COUNTY	
STREET ADDRESS		CITY		STATE		ZIP CODE	
MAILING ADDRESS		CITY		STATE		ZIP CODE	
HOME PHONE NUMBER		CELL NUMBER		EMAIL ADDRESS			

HOUSEHOLD MEMBER INFORMATION (A legend for completing this section is at the bottom of the page)

NAME (FIRST AND LAST) USE ROW 1 FOR PERSON LISTED ABOVE	RELATION TO HEAD OF HOUSEHOLD	Marital Status	DATE OF BIRTH	GENDER (circle one)	SOCIAL SECURITY NUMBER OR I-94 NUMBER	DISABILITY (circle one)	HEALTH INSURANCE	HISPANIC, LATINO, OR OF SPANISH ORIGIN?	RACE	MILITARY STATUS (circle one)	HIGHEST LEVEL OF EDUCATION	EMPLOYMENT (work status)	INCOME PERIOD
1	HEAD OF HOUSEHOLD			MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
2				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
3				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
4				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
5				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
6				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
7				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
8				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			

HOW MANY HOUSEHOLD MEMBERS ARE: A U. S. Citizen _____ Homebound _____ **A disconnected youth (age: 14-24) who is neither working or in school** _____

LEGEND FOR COMPLETING THE HOUSEHOLD MEMBER SECTION

RELATION TO HH	DOB	MARITAL STATUS	SS NUMBER OR I-94 NUMBER	HEALTH INSURANCE	RACE	HIGHEST LEVEL OF EDUCATION	EMPLOYMENT (WORK STATUS)
<ul style="list-style-type: none"> Head of Household Spouse Child Foster Child Grandchild Sibling Parent Grandparent Other Relative Not Related 	<ul style="list-style-type: none"> Date Format 99/99/99 	<ul style="list-style-type: none"> Married Single Divorced Widowed 	<ul style="list-style-type: none"> Social Security Number Format: 999-99-9999 I-94 Format (11 numbers) 999999999 99 <p>INCOME PERIOD</p> <ul style="list-style-type: none"> Weekly Bi-Weekly Semi-Monthly Monthly Quarterly Annually 	<ul style="list-style-type: none"> Medicaid Medicare State Children's Health Insurance Program State Health Insurance for Adults Military Health Care Direct Purchase Employment Based None 	<ul style="list-style-type: none"> American Indian Alaska Native Asian White Black or African American Native Hawaiian and Other Pacific Islander Other Multi-Race 	<ul style="list-style-type: none"> 0-8th Grade 9th-12th Grade/non-graduate High School Graduate (or equivalency diploma) 12th Grade + some post-secondary school College Graduate (2 or 4 year) Graduate of other post-secondary school 	<ul style="list-style-type: none"> Employed (Full-Time-FT) Employed (Part-Time-PT) Migrant Seasonal Farm Worker Unemployed (short-term, 6 months or less) Unemployed (long-term, more than 6 months) Unemployed (not in labor force) Retired

3. HOUSEHOLD TYPE (check one)

<input type="checkbox"/> Single Person	<input type="checkbox"/> Single Parent Female	<input type="checkbox"/> Single Parent Male	<input type="checkbox"/> Two Parent Household
<input type="checkbox"/> Two Adults No Children	<input type="checkbox"/> Multi-Generational Household	<input type="checkbox"/> Non-Related Adults with Children	<input type="checkbox"/> Other

4. HOUSEHOLD INCOME SOURCES (check all that apply)

For each household income source you check, you must include proof of income documentation with this application. For EMPLOYMENT INCOME, provide copies of your check stubs for the 30 days preceding this application, or provide a copy of your federal income tax return. For SELF-EMPLOYMENT INCOME or FARM INCOME, provide a copy of your federal income tax return.

<input type="checkbox"/> Employment Income (salary/wages)	<input type="checkbox"/> SSI (Supplemental Security Income)	<input type="checkbox"/> Private Disability Insurance	<input type="checkbox"/> SSDI (Social Security Disability Income)
<input type="checkbox"/> Self-Employment or Farm Income	<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> Alimony or Spousal Support	<input type="checkbox"/> Social Security Retirement Income
<input type="checkbox"/> VA Service Connected Disability Compensation	<input type="checkbox"/> Child Support	<input type="checkbox"/> General Relief/Assistance	<input type="checkbox"/> Unemployment Insurance/Benefits
<input type="checkbox"/> VA Non-Service Connected Disability Compensation	<input type="checkbox"/> Pension	<input type="checkbox"/> TANF/FIP Assistance	<input type="checkbox"/> No Income
<input type="checkbox"/> Other:			

Does your household have savings over \$50,000 (include: all savings and checking accounts, CDs, and other investments)? YES NO
Did anyone in your household file a tax return and receive the EITC (Earned Income Tax Credit) benefit last year or this year? YES NO

HOUSEHOLD NON Cash Benefits (Check all that apply)

<input type="checkbox"/> WIC (Women, Infants & Children)	<input type="checkbox"/> Public Housing	<input type="checkbox"/> Permanent Supportive Housing	<input type="checkbox"/> LIHEAP	<input type="checkbox"/> Affordable Care Act Subsidy	<input type="checkbox"/> SNAP (Food Stamps)
<input type="checkbox"/> Housing Choice Voucher (HCV)	<input type="checkbox"/> HUD-VASH Veteran's Affairs Supportive Housing	<input type="checkbox"/> Child Care Voucher	<input type="checkbox"/> Other _____		

HOUSING STATUS (check one) OWN RENT OTHER PERMANENT HOUSING HOMELESS (if homeless, what is your housing status?) OTHER **What are your Mortgage or Rent costs per month?** \$

- If you rent, are your heating costs included in your rent? Yes No
- If you Rent, do you receive RENT assistance? Yes No
- If you Rent, if your rent based on a percentage of your income? Yes No

HOUSING TYPE

House Mobile Home Rent a Room 2, 3, or 4 Unit Apt. 5 or more Unit Apt. Other

IF YOUR HEAT IS INCLUDED IN YOUR RENT, YOU MUST INCLUDE A COPY OF YOUR LEASE.

LANDLORD/COMPLEX INFORMATION

NAME	ADDRESS	PHONE
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MAIN SOURCE OF HOME HEATING You must include copies of your most recent Heating Bill and Electric Bill.

Natural Gas Electric Propane (LP) Fuel Oil Wood/Coal/Corn Other

* If propane or fuel oil, do you have an empty tank (20% or less or in the red)? Yes No

DO YOU HAVE A DISCONNECT NOTICE? YES NO
ARE YOU CURRENTLY DISCONNECTED? YES NO

* Please provide copy of disconnect notice with application.

HOUSEHOLD HEATING AND ELECTRIC COMPANIES

Heating Vendor	Electric Vendor
Account Name	Account Name
Account Number	Account Number

CERTIFICATION STATEMENT

I certify under penalty of perjury the above information is true. I give permission to the agency processing this application to acquire additional information and to share information with other organizations for the purposes of providing services to assist my household. This sharing of information is to be conducted with maximum respect for the confidentiality of the information contained in this application.

I am hereby making application for assistance to Operation Threshold for any of the following programs: LIHEAP, CSBG, CDBG, HOME, EFSP. **I further certify the following:** I declare that I am the only person in the household who has or will apply for this program(s). I understand that this information will be used, upon request, in determining eligibility for other agency programs or services. Any willful misrepresentation of the information on this form is subject to a penalty of law. I assure that any payments received will be used solely for the needs stated on my application and verified by Operation Threshold Staff. I understand that by signing (either in written form or electronically) this application, I am authorizing the assistance to be provided and vendor to be paid.

I hereby give permission to the State of Iowa, the U.S. Department of Energy, U.S. Department of Health and Human Services, U.S. Department of Housing and Urban Development and the agency processing this application to obtain additional information as relevant to completing and verifying my application for assistance. This includes permission to the State of Iowa to release application information to my energy supplier and to provide details about my account and energy use to the LIHEAP and Weatherization Assistance Program.

I understand this statement.

APPLICANT SIGNATURE

DATE