

LIHEAP PARTICIPANT ASSESSMENT APPLICATION

The application process begins the date your completed and signed application and all supporting documents are received.

Application Type	<input type="checkbox"/> Energy Assistance (<i>Low-Income Home Energy Assistance Program</i>)			
Application Date				
Applicant Last Name				
Applicant First Name		Middle		
Mailing Address				
Mailing City		State		Zip Code
Residential Address	<input type="checkbox"/> Same as Mailing Address <input type="checkbox"/> Other:			
Residential City		State		County
Home Phone		Cell Phone		Work Phone
Okay to Email?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Email Address	
How would you like to receive your benefit notification?	<input type="checkbox"/> Mail <input type="checkbox"/> Email			
How did you hear about this program?	<input type="checkbox"/> Letter from This Agency <input type="checkbox"/> Television Ad <input type="checkbox"/> Social Media Post by This Agency <input type="checkbox"/> Referred by Family/Friend <input type="checkbox"/> Email from This Agency <input type="checkbox"/> Radio Ad <input type="checkbox"/> Social Media Post by My Utility <input type="checkbox"/> Referred by Another Agency <input type="checkbox"/> Visit from This Agency <input type="checkbox"/> Newspaper Ad <input type="checkbox"/> Community Event with this Agency <input type="checkbox"/> Referred by My Utility Company <input type="checkbox"/> Poster/Flyer <input type="checkbox"/> Other:			
Household Type	<input type="checkbox"/> Single Person <input type="checkbox"/> Single Parent, Female <input type="checkbox"/> Two Adults, No Children <input type="checkbox"/> Unknown <input type="checkbox"/> Two Parents w/Children <input type="checkbox"/> Single Parent, Male <input type="checkbox"/> Unrelated Adults <input type="checkbox"/> Other:			
Number of Household Members	Please count <u>all</u> persons living in your home			

Household Members - Please answer these questions for <u>everyone</u> in your home. Print another copy of this page to include other members if needed.				
Relationship to HOH				
Name				
Date of Birth				
Social Security #				
Ethnicity	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
Race	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
US Citizen	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disabling Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Non-Cash Benefits (Check <u>All</u> That Apply)	<input type="checkbox"/> SNAP (Food Stamps)	<input type="checkbox"/> SNAP (Food Stamps)	<input type="checkbox"/> SNAP (Food Stamps)	<input type="checkbox"/> SNAP (Food Stamps)
	<input type="checkbox"/> WIC	<input type="checkbox"/> WIC	<input type="checkbox"/> WIC	<input type="checkbox"/> WIC
	<input type="checkbox"/> Housing Choice Voucher (HUD Voucher)	<input type="checkbox"/> Housing Choice Voucher (HUD Voucher)	<input type="checkbox"/> Housing Choice Voucher (HUD Voucher)	<input type="checkbox"/> Housing Choice Voucher (HUD Voucher)
	<input type="checkbox"/> PSH (Permanent Supportive Housing)	<input type="checkbox"/> PSH (Permanent Supportive Housing)	<input type="checkbox"/> PSH (Permanent Supportive Housing)	<input type="checkbox"/> PSH (Permanent Supportive Housing)
	<input type="checkbox"/> HUD-VASH	<input type="checkbox"/> HUD-VASH	<input type="checkbox"/> HUD-VASH	<input type="checkbox"/> HUD-VASH
	<input type="checkbox"/> Childcare Voucher	<input type="checkbox"/> Childcare Voucher	<input type="checkbox"/> Childcare Voucher	<input type="checkbox"/> Childcare Voucher
	<input type="checkbox"/> Affordable Care Act Subsidy	<input type="checkbox"/> Affordable Care Act Subsidy	<input type="checkbox"/> Affordable Care Act Subsidy	<input type="checkbox"/> Affordable Care Act Subsidy
	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
Income Sources (Check <u>All</u> That Apply)	<input type="checkbox"/> Wages	<input type="checkbox"/> Wages	<input type="checkbox"/> Wages	<input type="checkbox"/> Wages
	<input type="checkbox"/> Social Security	<input type="checkbox"/> Social Security	<input type="checkbox"/> Social Security	<input type="checkbox"/> Social Security
	<input type="checkbox"/> VA Benefits	<input type="checkbox"/> VA Benefits	<input type="checkbox"/> VA Benefits	<input type="checkbox"/> VA Benefits
	<input type="checkbox"/> Child Support	<input type="checkbox"/> Child Support	<input type="checkbox"/> Child Support	<input type="checkbox"/> Child Support
	<input type="checkbox"/> Pension	<input type="checkbox"/> Pension	<input type="checkbox"/> Pension	<input type="checkbox"/> Pension
	<input type="checkbox"/> Unemployment	<input type="checkbox"/> Unemployment	<input type="checkbox"/> Unemployment	<input type="checkbox"/> Unemployment
	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

Housing Details - Please provide details about your home				
Housing Type	<input type="checkbox"/> Single Family Home	<input type="checkbox"/> Mobile Home	<input type="checkbox"/> Manufactured Home	<input type="checkbox"/> Multi-family (1-3 Units)
				<input type="checkbox"/> Multi-family (4+ Units)
Occupancy Status	Rent Subsidized?	Heat Included in Rent?		
<input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Homeless	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Fuel Details - Please provide details on how you heat your home.				
Primary Heat Source (Select <u>one</u>)	<input type="checkbox"/> Electricity	<input type="checkbox"/> Coal	<input type="checkbox"/> Propane (Delivered)	<input type="checkbox"/> Wood (Corded)
	<input type="checkbox"/> Natural Gas	<input type="checkbox"/> Oil	<input type="checkbox"/> Propane (Small Bottles)	<input type="checkbox"/> Firelogs
				<input type="checkbox"/> Wood Pellets
				<input type="checkbox"/> Other:
Primary Heat Vendor	Account Number			
Are you facing an emergency with your Primary Heat Source?	<input type="checkbox"/> No <input type="checkbox"/> Yes, my primary heat source has been disconnected <input type="checkbox"/> Yes, I am out of my primary heating fuel <input type="checkbox"/> Yes, I will be disconnected on: <input type="checkbox"/> Yes, I will run out of my primary heating fuel within 48 hrs.			
Electricity Vendor	Account Number			
Are you facing an emergency with your electricity account?	<input type="checkbox"/> No <input type="checkbox"/> Yes, my electricity has been disconnected <input type="checkbox"/> Yes, I will be disconnected on:			
Other Heat Source(s) (Select all that apply)	<input type="checkbox"/> Electricity	<input type="checkbox"/> Oil	<input type="checkbox"/> Propane (Delivered)	<input type="checkbox"/> Wood (Corded)
	<input type="checkbox"/> Natural Gas	<input type="checkbox"/> Coal	<input type="checkbox"/> Propane (Small Bottles)	<input type="checkbox"/> Firelogs
				<input type="checkbox"/> Wood Pellets
				<input type="checkbox"/> Other:
Other Heating Vendor(s)	Account Number(s)			

Heating/Cooling System(s) and Water Heater Details - Please provide details about these systems within your home	
Heating System Condition	<input type="checkbox"/> Operable <input type="checkbox"/> Inoperable <input type="checkbox"/> Failing <input type="checkbox"/> I do not have a heating system
Cooling System Condition	<input type="checkbox"/> Operable <input type="checkbox"/> Inoperable <input type="checkbox"/> Failing <input type="checkbox"/> I do not have a cooling system

Nondiscrimination Notice

If you believe you have been discriminated against because of race, color, sex, handicap, national origin, religious creed, or political belief, you can file a complaint. Complaint forms are available from the address listed below or at the assistance provider listed above.

DEPARTMENT OF HEALTH AND WELFARE
CIVIL RIGHTS AFFIRMATIVE ACTION SECTION
PO BOX 83720; BOISE, ID; 83720-0036

Your Rights

If your application for assistance is denied, you will be notified in writing of the reason for the denial. If you are dissatisfied with this decision or feel you have been discriminated against in any way, you have thirty (30) days from the date the notice is mailed in which to request a fair hearing using form HW 0406. If you file a fair hearing request, you will have a right to find out if your eligibility for the LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM and/or LOW-INCOME WEATHERIZATION ASSISTANCE PROGRAM was incorrectly determined according to State and Federal law and policy.

Privacy Act and Information Release

Under Section 3(e)(3) of the Privacy Act of 1974, 5 U.S.C. 552 a(e)(3), each agency that maintains a system of records shall inform each individual from whom it solicits information of the authority which permits the solicitation of the information; whether disclosure is voluntary; the principal purpose for which the information is intended to be used; the routine uses which may be made of the information; and the consequences, if any, resulting from failure by the individual to provide the requested information. This statement is required by the Privacy Act to be furnished prior to the collection and use of the information requested. You may retain this statement for your records.

Authority: The specific authority for the maintenance of this report is in sections 416 and 417 of the Energy Conservation and Production Act, Pub. L. 94 385. These sections direct Federal and State agencies, which are sponsoring these programs, to monitor the effectiveness of the programs, and to require the local Non-Profit agency implementing the programs to keep records to enable program monitoring.

Your responses to the request for information are entirely voluntary, however should you decline to provide the information requested, you will not be considered for assistance. Please initial each of the four items below if you agree with each

Participant Certification - *Please initial each line and sign below to certify the accuracy of the information you provided*

I understand that completion of this application does not constitute immediate approval for assistance.

I hereby give my permission for the release of any information needed to process this application to a Representative of the Department of Health and Welfare and/or Non-Profit agency, organization or their designee or to any state and federal agency, as required by law.

I understand my information will be held in accordance with IDHW Confidentiality Regulations.

I hereby authorize my energy vendor(s) to provide my billing and usage data to the representative of IDHW and/or this agency or their designee.

Under penalty of perjury, I certify that the information contained in this application is true and correct. I understand that I am applying for federal benefits and I could be sanctioned and required to return any benefits I receive if I willfully misrepresent and/or conceal facts. Sanctions may include administrative, civil, or criminal actions against me, including prosecution.

Participant Signature		Date	
Agency Representative		Date	



Eastern Idaho Community Action Partnership

Universal Intake

Did you apply due to COVID-19? Yes No

Household Information				
Relationship to HOH	Head of Household (Self)	2 nd Member	3 rd Member	4 th Member
Name				
Military Status	<input type="checkbox"/> Veteran <input type="checkbox"/> Active Military <input type="checkbox"/> N/A	<input type="checkbox"/> Veteran <input type="checkbox"/> Active Military <input type="checkbox"/> N/A	<input type="checkbox"/> Veteran <input type="checkbox"/> Active Military <input type="checkbox"/> N/A	<input type="checkbox"/> Veteran <input type="checkbox"/> Active Military <input type="checkbox"/> N/A
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Other _____	<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Other _____	<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Other _____	<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Other _____
Health Insurance <i>(Please mark all that apply)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Medicaid <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Medicare <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> <input type="checkbox"/> Employer Provide Health Insurance <input type="checkbox"/> Veteran's Administration (VA) Medical Services <input type="checkbox"/> <input type="checkbox"/> Indian Health Service Program <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Medicaid <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Medicare <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> <input type="checkbox"/> Employer Provide Health Insurance <input type="checkbox"/> Veteran's Administration (VA) Medical Services <input type="checkbox"/> <input type="checkbox"/> Indian Health Service Program <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Medicaid <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Medicare <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> <input type="checkbox"/> Employer Provide Health Insurance <input type="checkbox"/> Veteran's Administration (VA) Medical Services <input type="checkbox"/> <input type="checkbox"/> Indian Health Service Program <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Medicaid <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Medicare <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> <input type="checkbox"/> Employer Provide Health Insurance <input type="checkbox"/> Veteran's Administration (VA) Medical Services <input type="checkbox"/> <input type="checkbox"/> Indian Health Service Program <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Other _____

OFFICE USE ONLY: Department _____ **Program** _____ **Date of Intake** _____ **Client ID#** _____ **Intake Worker:** _____

Employment Type	<input type="checkbox"/> Full Time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed (6 months or less) <input type="checkbox"/> Self-employment <input type="checkbox"/> Unemployed (more than 6 months) <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed (Not in Labor Force)	<input type="checkbox"/> Full Time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed (6 months or less) <input type="checkbox"/> Self-employment <input type="checkbox"/> Unemployed (more than 6 months) <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed (Not in Labor Force)	<input type="checkbox"/> Full Time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed (6 months or less) <input type="checkbox"/> Self-employment <input type="checkbox"/> Unemployed (more than 6 months) <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed (Not in Labor Force)	<input type="checkbox"/> Full Time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed (6 months or less) <input type="checkbox"/> Self-employment <input type="checkbox"/> Unemployed (more than 6 months) <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed (Not in Labor Force)
Education	<input type="checkbox"/> Grades 0-8 <input type="checkbox"/> 12 grade + Some post- Secondary <input type="checkbox"/> Grades 9-12 / Non-Graduate <input type="checkbox"/> Graduate of other Post-Secondary school <input type="checkbox"/> High School Graduate / Equivalency Diploma <input type="checkbox"/> Other _____	<input type="checkbox"/> Grades 0-8 <input type="checkbox"/> 12 grade + Some post- Secondary <input type="checkbox"/> Grades 9-12 / Non-Graduate <input type="checkbox"/> Graduate of other Post-Secondary school <input type="checkbox"/> High School Graduate / Equivalency Diploma <input type="checkbox"/> Other _____	<input type="checkbox"/> Grades 0-8 <input type="checkbox"/> 12 grade + Some post- Secondary <input type="checkbox"/> Grades 9-12 / Non-Graduate <input type="checkbox"/> Graduate of other Post-Secondary school <input type="checkbox"/> High School Graduate / Equivalency Diploma <input type="checkbox"/> Other _____	<input type="checkbox"/> Grades 0-8 <input type="checkbox"/> 12 grade + Some post- Secondary <input type="checkbox"/> Grades 9-12 / Non-Graduate <input type="checkbox"/> Graduate of other Post-Secondary school <input type="checkbox"/> High School Graduate / Equivalency Diploma <input type="checkbox"/> Other _____
Currently in school	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:

I certify that the information above is correct and true to the best of my knowledge and understand that further verification for EICAP programs may be required for participation in those programs.
 Are you willing to make a long-term commitment to share feedback? Yes No

Participant Signature		Date	
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Office Use Only: Verbal Verification Yes No Intake for verbal:

Referral Questions

LIHEAP PY 20

To Help US Better Serve YOU Please answer the questions below:

Does your Household need assistance with your home heating bills? Are you currently up for a disconnect with your power? If YES, please select your local EICAP office to receive further information:

EICAP- Idaho Falls

EICAP – Rexburg

EICAP - Salmon

Does your family have enough food to get through the month? If NO, please select your local EICAP office to receive further information:

EICAP – Rexburg

EICAP – Salmon

EICAP-Challis

Are you or a member of the household interested in completing their GED? If YES, please select your local EICAP office to receive further information:

EICAP - Haven – Idaho Falls

EICAP - Salmon

Does a member of your household need assistance with higher education? If YES, please select your local EICAP office to receive further information:

EICAP- Idaho Falls

EICAP – Rexburg

Do you have a child under the age of five? If Yes and you would like to receive further information, please ~~un~~ give your local Head Start Center:

Early Head Start Ages 0-3

Head Start Ages 3-5

Are you interested in weatherizing your home? Please select YES or NO

Does your home heating equipment currently work? `Please select YES or NO

Do you know about meals available at the local Senior Center? If NO, please select “Senior Meal Program” to receive further information:

Senior Meal Programs

Do you provide the majority of care for a loved one? If YES, please select “Caregiver Services” to receive further information on services available:

Caregiver Services

Do you need assistance with completing daily activities, household tasks, and /or maintaining the safety in your home? If YES, please select “In Home Assistance” to receive further information on services available:

In Home Assistance

Would you like to be contacted for information on Senior Services? If YES, please select “Information and Assistance” to receive further information:

Information and Assistance

IF YOU HAVE QUESTIONS PLEASE ASK!

Universal Supplemental Survey

Due to the COVID-19 pandemic we are trying to identify what the needs are in the communities that we serve, so that we can have a better idea of where we can focus our efforts and services. **Would you be willing to tell us what your top 3 needs are at this time and how has COVID-19 impacted you and your family?**

(Please check mark your top 3 needs if applicable)

- Employment:
 - Seeking Employment due to layoff or furlough*
 - Do you need assistance to purchase employment supplies?*
 - *Please specify what type of supplies:*
 - Other: _____*
- Education:
 - Tuition Assistance*
 - *School Attending:*
 - GED classes*
 - Tutoring classes for children*
 - *Children Age:*
 - Education Assistance /Supplies*
 - *Access to internet*
 - *Access to printing*
 - *What type of supplies:*
 - Other: _____*
- Housing:
 - Rental Assistance*
 - *Monthly Rent:*
 - In danger of Eviction*
 - Utility Assistance*
 - Other: _____*
- Health:
 - Food Assistance*
 - Medication Assistance*
 - Medical Assistance*
 - Mental health assistance (do you know someone struggling with how COVID -19 is affecting family, friends or themselves)*
 - Other: _____*
- Transportation
 - Gas Voucher*
 - Other: _____*

How has COVID-19 impacted you and your family?
