

Locality/FIPS \_\_\_\_\_ Case # \_\_\_\_\_ Date Application Received \_\_\_\_\_ Worker # \_\_\_\_\_

**COOLING ASSISTANCE APPLICATION**

*Applications accepted from June 15 through August 15*

PLEASE ANSWER ALL QUESTIONS COMPLETELY

In what city or county do you live? \_\_\_\_\_

**PART I**

Name \_\_\_\_\_ SEX:   M  F  
 Physical/Service Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_ Day Phone: \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Directions to home \_\_\_\_\_ Email Address \_\_\_\_\_

**PART II**

- What is your cooling need? (Check all that apply)  
 **A.** Pick up portable fan       **B.** Purchase/install window air conditioner      Do you have at least one working air conditioner in your home?  YES  NO      (You cannot receive a window air conditioner if you already have a working air conditioner of any type in your home. The local agency may call you or visit your home to confirm you do not have a working air conditioner.)  
 **C.** Repair central air conditioner or heat pump       **D.** Payment of electric deposit       **E.** Purchase/install ceiling, attic or whole house fan  
 **F.** Repair ceiling, attic or whole house fan       **G.** Payment of electric bill       **H.** Self-pick-up/install window air conditioner
- Circle the letter that best describes your present living situation. Read each one before you choose. Circle only one.  
**A.** I own or am buying my home and pay all cooling bills.      **G.** I live in Section 8 housing, HUD, subsidized housing, & regularly pay some or all of my cooling bills.  
**B.** I own or rent my home and do not pay a cooling bill.      **I.** I live in one room in someone else's house.  
**C.** I pay rent and also pay for cooling separately.      **L.** I live in an institution, group home, treatment center or home for adults.  
**E.** I pay rent & my cooling is included in the rent payment.      **P.** I live rent-free in more than one room, house or apartment and pay for heat/cooling.  
**F.** I live in subsidized housing Section 8, HUD, Public Housing, and occasionally pay excess usage charges.      **Q.** I live in an emergency shelter or I am homeless. I have arranged to move into a house, apartment or more than one room.
- Are all people in your household United States citizens?  YES  NO      If no, who? \_\_\_\_\_ What is their Alien Status? \_\_\_\_\_
- Is anyone in your household disabled?  YES  NO      If yes, who? \_\_\_\_\_
- How many people live in your household? # \_\_\_\_\_
- Is anyone temporarily out of the home?  YES  NO      If yes, who? \_\_\_\_\_ Expected Date of Return? \_\_\_\_\_

**List yourself first and every person living in the home. List the Social Security Number for everyone who lives in your home. Complete information for each person.**

NAME	RELATION TO PERSON ON LINE #1	SOCIAL SECURITY#	DATE OF BIRTH	RACE	HISPANIC OR LATINO		WORKING		GROSS MONTHLY INCOME AMOUNT	INCOME PAID weekly, biweekly, semi-monthly, monthly	LIST ALL SOURCES OF INCOME Earned Income (List the Name of Employer/Company); Self-employment; Social Security; SSI; Veterans Benefit; Child Support; etc.
					Yes (Y)	No (N)	Yes (Y)	No (N)			
	<b>Self</b>										

7. Circle ALL types of household income:      A. TANF      B. Social Security      C. SSI      D. Unemployment      E. Employment or Self-employed      G. General Relief  
 H. Veterans Benefits      N. Worker's Compensation      Q. Child Support or Alimony      U. Rental Income      W. Retirement      Other: specify \_\_\_\_\_
8. Do you receive payments from the Division of Child Support Enforcement?  YES  NO How much? \_\_\_\_\_ Who pays the child support? \_\_\_\_\_
9. Did you or any household member receive Fuel, Crisis, or Cooling Assistance in the past 12 months?  YES  NO If yes, case name \_\_\_\_\_
10. Does any household member receive SNAP benefits (formerly Food Stamps)?  YES  NO If yes, case name(s) \_\_\_\_\_
11. Does any household member receive Medicaid?  YES  NO If yes, case name(s) \_\_\_\_\_
12. Is Medicaid Home & Community-Based Care received?  YES  NO If yes, by whom? \_\_\_\_\_ Patient pay amount \$ \_\_\_\_\_
13. Does anyone pay for Medicare, Part B  or D  insurance?  YES  NO If yes, who? \_\_\_\_\_ How much? \$ \_\_\_\_\_
14. Circle every type of cooling equipment that is in your home.      None      Portable fan      Ceiling fan      Attic fan      Whole House fan  
 Window Air Conditioner      Central Air Conditioning Unit      Heat Pump
15. Does the cooling equipment in your home work?  YES  NO If NO, list all equipment that does NOT work. \_\_\_\_\_
16. Who owns or is responsible for any cooling equipment in your home? \_\_\_\_\_
17. Name and address of the company used for home cooling. \_\_\_\_\_  
*Verification from the utility company is needed if you cool with electricity. Attach a copy of your current electric bill. Complete the following:*
- In whose name is the bill? \_\_\_\_\_ Account Number \_\_\_\_\_ Who is responsible for paying the bill? \_\_\_\_\_  
 Is the utility payment made by an automatic monthly withdrawal or debit/credit payment?  YES  NO Do you have a PrePay electric service account?  YES  NO
18. Where else have you applied for this assistance? \_\_\_\_\_
19. Do you have a heating expense?  YES  NO If YES, what is your fuel type? Circle the fuel used most frequently to heat your house. **CIRCLE ONLY ONE.**  
 1. Electricity      2. Natural Gas      3. Fuel Oil (#2)      4. Clear Kerosene      5. Coal      6. Wood      7. LP/Bottled Gas      8. Red Kerosene
20. Name and address of the company used for home heating. \_\_\_\_\_
21. What is the **account name** on your heating bill? \_\_\_\_\_ What is the **account number** on your heating bill? \_\_\_\_\_
22. Circle the primary heating equipment used to heat your home. **CIRCLE ONLY ONE.**  
 A. Furnace      B. Radiator      C. Portable Heater      D. Vented Space Heater      E. Baseboard Heat      F. Heat Pump  
 G. Fireplace      H. Wood Stove or Coal Stove      J. Cook stove      K. None      L. Unknown
23. Does your household owe a past due amount on your electric account?  YES  NO If yes, how much is the past due amount? \_\_\_\_\_
24. Has your household received a shutoff notice for electricity?  YES  NO If yes, when will your electric service be disconnected? \_\_\_\_\_
25. Has your household's electricity been disconnected?  YES  NO If yes, when did your electric service end? \_\_\_\_\_

**APPLICANT'S CERTIFICATION**

I certify that the above statements and attachments are true and correct to the best of my knowledge. I will notify the Department of Social Services (DSS) within 5 days of any changes that occur in my situation. I understand that I or any member of my household cannot sell merchandise purchased on my behalf through the program unless the local DSS has granted permission to sell. Any benefits received must be used for the purpose approved. I may file a complaint if I feel I have been discriminated against because of my race, color, national origin, disability, sex, age, political beliefs, religion, sexual orientation, marital or family status. If I give false information, withhold information, fail to report changes promptly, or obtain assistance for which I am not eligible, I may be breaking the law and could be prosecuted for perjury, larceny and/or fraud. If I completed, or assisted in completing this application form and aided and abetted the applicant to obtain assistance for which he/she is not eligible, I may be breaking the law and could be prosecuted. I understand the DSS may use information on this application or that I may be contacted for the purposes of research, evaluation, and analysis to the extent allowed by state and federal law. My signature authorizes the DSS to obtain any verification to establish my household's eligibility for assistance or to give information in my case record to other organizations from which I have received or requested assistance. I understand that, by providing my energy supplier(s)/ account information, I am authorizing the energy supplier(s) to provide details about my account and energy use to the DSS for the purposes of program verification, evaluation, reporting, and analysis. I agree to hold harmless and/or release my energy supplier(s) from and against any claims, losses, demands, damages, or liability of any kind caused by or allegedly caused by such disclosure.

**Applicant's Signature OR Mark:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Witness to Mark or Interpreter:** \_\_\_\_\_ **Phone Number** \_\_\_\_\_ **Date** \_\_\_\_\_

**Completed on behalf of applicant by:** \_\_\_\_\_ **Phone Number** \_\_\_\_\_ **Date** \_\_\_\_\_