DEL NORTE SENIOR CENTER
ENERGY PROGRAM APPLICATION

RETURN TO: 1765 NORTHCREST DRIVE, CRESCENT CITY, CA 95531
Email to: energyua@dnsc1.org

Applicant First Name **(This person MUST come to the appointment)**	Middle Int.	Last Name

Applicant Social Security No.	Applicant Date of Birth (mm/dd/yyyy)	Telephone ☐ Check if Message only

Spouse/Other Adult Houshold Member First Name	Middle Int.	Last Name

Service/Street Address (Do not use P.O. Box) ☐ Check if you've lived here all of prior 12 months.	Unit Number

Service City	Service County	Service State	Service ZIP Code
	Del Norte	CA	

Mailing Address ☐ Check if same as service/street address.	Unit Number

Mailing City	Mailing County	Mailing State	Mailing ZIP Code
	Del Norte	CA	

HOUSEHOLD INFORMATION

PEOPLE LIVING IN HOUSEHOLD Enter the number of people who are:	
2 years old or younger	
Ages 3 - 5 years	
Ages 6 - 18 years	
Ages 19 - 59	
Ages 60 or older	
TOTAL PEOPLE IN HH	0
HOUSEHOLD DEMOGRAPHICS	
Enter the number of people who are:	
Disabled	
Native American	
Limited-English Speaking	
Seasonal or Migrant Farmworker	

INCOME How many people in the household receive income?	
Enter total gross (pre-tax) **monthly** income for all people living in the household:	
TANF	$
SSI/SSP	$
SSA/SSDI	$
Paycheck(s)	$
Interest	$
Pension	$
Self-Employment	$
Other	$
TOTAL INCOME	$ 0.00

TYPE OF HOUSING

- ☐ Single-Family Home/ House
- ☐ Mobile Home
- ☐ Duplex/Apartment complex with fewer than 4 units.
- ☐ Apartment complex with more than 4 units.
- ☐ Other

Do you:

- ☐ Own ☐ Rent
- ☐ Other

Are you or someone in your household CURRENTLY receiving CalFresh (Food Stamps)? ☐ YES ☐ NO

PLEASE COMPLETE AND SIGN PAGE 2

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ELECTRIC UTILITIES - YOU MUST SUBMIT A COPY OF YOUR MOST RECENT BILL

All Electric? ☐ YES ☐ NO | ☐ Pacific Power & Light ☐ Included in rent/submetered. ☐ Solar/Off-grid. ☐ None/Other

Account Number	Name of customer on utility bill:
Do you have a past due amount? ☐ YES ☐ NO	Is your electricity shut off? ☐ YES ☐ NO

HOME HEATING FUEL - YOU MUST SUBMIT A COPY OF YOUR MOST RECENT BILL OR RECEIPT

Which fuel are you requesting assistance for? (*SELECT ONLY ONE*)

☐ Electricity ☐ Fuel Oil ☐ Pellets
☐ Propane ☐ Wood ☐ Other
☐ Kerosene Specify Other:_____

Do you have any other source to heat your home?

☐ No ☐ Fuel Oil ☐ Propane
☐ Pellets ☐ Wood ☐ Kerosene
☐ Electric Space Heater ☐ Other

Fuel Supply

Are you currently out of home heating fuel? ☐ YES ☐ NO

How many days until you run out? _____

Where do you usually buy home heating fuel?	Account Number

STATE PROGRAM INFORMATION: AGENCY NAME: Community Services and Development (CSD). UNIT RESPONSIBLE FOR MAINTENANCE: Home Energy Assistance Program (HEAP). AUTHORITY: Government Code Section 16367.6 (a) Names CSD as the agency responsible for managing HEAP. PURPOSE: The information you provide will be used to decide if you are eligible for a LIHEAP payment and/or weatherization services. GIVING INFORMATION: This program is voluntary. If you choose to apply for assistance, you must give all required information. OTHER INFORMATION: CSD uses statistical definitions from the annual update of the Department of Health and Human Services' State Median Income, Federal Income Poverty Guidelines, to determine program eligibility. During application processing, CSD's designated subcontractor may need to ask you for more information to decide your eligibility for either or both programs. ACCESS: CSD's designated subcontractor will keep your completed application and other information, if used, to determine your eligibility. You have the right to access all records holding information about you. CSD does not discriminate in the provision of services on the basis of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, marital status, sex, age, or sexual orientation.

APPEAL: I understand that if my application for LIHEAP/DOE benefits or services is denied, or if I receive untimely response or unsatisfactory performance, I may initiate a written appeal with the local service provider and my appeal shall be reviewed no later than 15 days after the appeal is received. If I am not satisfied with the local service provider's decision I may then appeal to the Department of Community Services and Development pursuant to Title 22, California Code of Regulations section 100805.

CONSENT/ INFORMATION VERIFICATION: The information on this application will be used to determine and verify my eligibility for assistance. My signature gives consent for this information to be shared with other offices of the state and federal governments, their designated subcontractors, my utility company(ies), and for my utility company(ies) to share my account information with CSD, its designated subcontractors, and other offices of the state and federal governments for the purpose of providing services to me and to coordinate, improve and reduce the costs of services under these programs. I further authorize my utility company(ies) to provide my energy consumption data to CSD to the extent necessary for CSD to comply with the program reporting requirements of the federal government. I understand that this consent shall remain in effect for three years from the date signed unless otherwise revoked by me in writing. I declare, under penalty of perjury, that the information on this application is true, correct, and that the funds received will be used solely for the purpose of paying my energy costs.

Applicant's Signature _____ *Date* _____ *Witness' Signature (if signed with an X)* _____

YOU MUST SUBMIT A COPY OF YOUR MOST RECENT UTILITY BILL WITH THIS APPLICATION.

DEL NORTE SENIOR CENTER
ENERGY PROGRAM

HOUSEHOLD MEMBER DEMOGRAPHIC INFORMATION

The following information is being requested to help us serve the community better. We use this information to learn more about the people who need our services. We may also use this information to offer your family a referral to other services that may be of benefit to you. Your information is confidential. We will never report, publish or share your individual information outside of the program for which you are applying without your permission. Please provide the following information for each member of your household. Thank you.

PLEASE BRING THE COMPLETED FORM WITH YOU TO YOUR APPOINTMENT

APPLICANT

First Name	Middle In	Last Name	Relationship to Applicant: Self

Date of Birth:
Gender:
Race: ☐ White/European ☐ Native Am/Alaskan ☐ Asian ☐ Black/African Am ☐ Hawaiian/Pacific Islander ☐ Multi-Racial ☐ Other: _____
Hispanic/Latino? ☐ Yes ☐ No

Education Level: ☐ 0-8th grade ☐ 9th to 12th Grade ☐ HS Graduate/GED ☐ Some College ☐ College Degree

Does this person have Health Insurance? ☐ No ☐ Medi-Cal ☐ Medicare ☐ Other/Private

Check all that apply: ☐ Disabled ☐ Limited English Speaking ☐ Farmer ☐ Migrant Farmworker ☐ Seasonal Farmworker

HOUSEHOLD MEMBER 1

First Name	Middle In	Last Name	Relationship to Applicant:

Date of Birth:
Gender:
Race: ☐ White/European ☐ Native Am/Alaskan ☐ Asian ☐ Black/African Am ☐ Hawaiian/Pacific Islander ☐ Multi-Racial ☐ Other: _____
Hispanic/Latino? ☐ Yes ☐ No

Education Level: ☐ 0-8th grade ☐ 9th to 12th Grade ☐ HS Graduate/GED ☐ Some College ☐ College Degree

Does this person have Health Insurance? ☐ No ☐ Medi-Cal ☐ Medicare ☐ Other/Private

Check all that apply: ☐ Disabled ☐ Limited English Speaking ☐ Farmer ☐ Migrant Farmworker ☐ Seasonal Farmworker

HOUSEHOLD MEMBER 2

First Name	Middle In	Last Name	Relationship to Applicant:

Date of Birth:
Gender:
Race: ☐ White/European ☐ Native Am/Alaskan ☐ Asian ☐ Black/African Am ☐ Hawaiian/Pacific Islander ☐ Multi-Racial ☐ Other: _____
Hispanic/Latino? ☐ Yes ☐ No

Education Level: ☐ 0-8th grade ☐ 9th to 12th Grade ☐ HS Graduate/GED ☐ Some College ☐ College Degree

Does this person have Health Insurance? ☐ No ☐ Medi-Cal ☐ Medicare ☐ Other/Private

Check all that apply: ☐ Disabled ☐ Limited English Speaking ☐ Farmer ☐ Migrant Farmworker ☐ Seasonal Farmworker

HOUSEHOLD MEMBER 3

First Name	Middle In	Last Name	Relationship to Applicant:

Date of Birth:
Gender:
Race: ☐ White/European ☐ Native Am/Alaskan ☐ Asian ☐ Black/African Am ☐ Hawaiian/Pacific Islander ☐ Multi-Racial ☐ Other: _____
Hispanic/Latino? ☐ Yes ☐ No

Education Level: ☐ 0-8th grade ☐ 9th to 12th Grade ☐ HS Graduate/GED ☐ Some College ☐ College Degree

Does this person have Health Insurance? ☐ No ☐ Medi-Cal ☐ Medicare ☐ Other/Private

Check all that apply: ☐ Disabled ☐ Limited English Speaking ☐ Farmer ☐ Migrant Farmworker ☐ Seasonal Farmworker

HOUSEHOLD MEMBER 4

First Name	Middle In	Last Name	Relationship to Applicant:

Date of Birth:
Gender:
Race: ☐ White/European ☐ Native Am/Alaskan ☐ Asian ☐ Black/African Am ☐ Hawaiian/Pacific Islander ☐ Multi-Racial ☐ Other: _____
Hispanic/Latino? ☐ Yes ☐ No

Education Level: ☐ 0-8th grade ☐ 9th to 12th Grade ☐ HS Graduate/GED ☐ Some College ☐ College Degree

Does this person have Health Insurance? ☐ No ☐ Medi-Cal ☐ Medicare ☐ Other/Private

Check all that apply: ☐ Disabled ☐ Limited English Speaking ☐ Farmer ☐ Migrant Farmworker ☐ Seasonal Farmworker

Del Norte Senior Center Energy Program
DNSC 43B (rev.03/2020)

CERTIFICATION OF INCOME AND EXPENSES

This form must be completed if a household is asking for assistance, and states that one or more adult members of the household cannot provide proof of income. The State of California requires applicant households to report all sources of income. This form will help us understand how you are meeting expenses. Please complete the information below for any adult household member reporting zero income:

Name and Address	
Name:	
Address:	

Section 1: Do you have sources of income you forgot to report? If yes, you must list the income on the application, page 1		
☐YES	☐NO	During the previous month have you been employed part time?
☐YES	☐NO	During the previous month have you been self-employed?
☐YES	☐NO	During the previous month did you receive money for any work that you perform only once in a while, like yard work, child care, donating blood, etc?
☐YES	☐NO	During the previous month have you received any gifts of money from anyone? If yes, please list the name and phone number of the person who gave you the gift:
☐YES	☐NO	During the previous month did you receive any of the following: (circle any that apply) ☐ WORKER'S COMP ☐ UNEMPLOYMENT ☐ GOVERNMENT SPONSORED BENEFITS ☐ CHILD SUPPORT
☐YES	☐NO	Do you receive any of the following (circle any that apply) ☐ ANNUITY PAYMENT ☐ PENSION ☐ TRIBAL CASINO PAYMENTS ☐ RENTAL INCOME ☐ INSURANCE BENEFITS

Section 2: Are you spending your savings or borrowing money to cover monthly expenses?		
☐YES	☐NO	Are you using savings or a home equity loan? How much? _____
☐YES	☐NO	Are you using some other asset? How much? _____
☐YES	☐NO	Are you borrowing from credit cards? How much? _____
☐YES	☐NO	Are you borrowing from some other source? How much? _____

Section 3: Please tell us how you paid these monthly expenses during the previous months:

EXPENSE	MONTHLY COST	HOW HAS THE EXPENSE BEEN PAID?	IF SOMEONE ELSE PAYS FOR YOU, PLEASE COMPLETE:	
Rent or Mortgage	$		Name:	Phone:
			Address:	
Utility Bills	$		Name:	Phone:
			Address:	
Food	$		Name:	Phone:
			Address:	

Section 4: If none of the above applies to you, please explain how your monthly expenses were paid:

_____

_____

_____

Signature:

By signing this form, I affirm that I believe these facts are accurate and true. I give the Service Provider my permission to verify this information. I may be held liable under federal or state law for knowingly making false or fraudulent statements.

_____ _____

Signature Date

Del Norte Senior Center
Energy Services
DNSC 559

UTILITY RESPONSIBILITY STATEMENT

APPLICANT LAST NAME _____ FIRST NAME _____ M.I. _____

SERVICE ADDRESS _____ UNIT _____ CITY _____ ZIP _____

☐ The utility bill at the above address is in my name. (You may stop here)

☐ The utility bill at the above address is in the name of: _____

This person is my _____.

☐ I must pay the entire amount of the utility bill each month.

☐ Part of the utility bill is include in my rent or sub-metered by my landlord. The amount of my rent that covers utilities, or the amount that is sub-metered for this month is $_____

Signature of Landlord _____ Date _____

Address _____ Phone Number _____

I certify that all information is true and correct to the best of my knowledge. I am aware that willfully and knowingly falsifying information may lead to criminal prosecution. I am the only person in my household who has applied for Energy Assistance.

Applicant's Signature _____ Date _____

DEL NORTE SENIOR CENTER

LIHEAP WPO ASSISTANCE

HOME HEATING FUEL MONTHLY USE AND COSTS

Applicant: _____

Address: _____

City: _____ State: CA Zip: _____

The primary heating source at the above address is: **Select**

In one month, I will use about: _____ **Select**
Amount Units

The usual vendor from which I purchase fuel is: _____

I (we) understand and acknowledge that any home heating fuel that I may receive from the Del Norte Senior Center Energy Programs is for the use of my (our) qualified household only. I (we) further understand that any use other than for my (our) own heating needs will be considered fraudulent and I (we) may be subject to arrest, prosecution and/or repayment of the full cost of services received if I (we) sell, give away, trade or otherwise improperly use any of the home heating fuel that I (we) have received from this program.

_____ _____
Applicant Signature Date

AGENCY USE ONLY

MONTHLY ENERGY COST CALCULATION

	X		=		+		=	
Units of Fuel		Cost per Unit		Total Monthly Fuel Cost		Monthly Electric Costs		Total Energy Cost*

*Enter Total Energy Cost into application for the purpose of determining energy burden.

Pacific Power CARE Program Application

Mail completed forms to: CARE Program Manager
Pacific Power
825 NE Multnomah, Suite 2000
Portland, OR 97232

For questions call toll-free: 1-888-221-7070

Pacific Power Customer Information: (All information is required. Please print clearly.)

Account Number: You can find this in the upper right hand corner of your Pacific Power bill.

☐☐☐☐☐☐☐☐☐☐☐☐

Name (as it appears on your Pacific Power bill)

Home address (no P.O. Boxes, please) City, State Zip

Mailing address (if different than your home address) City, State Zip

Daytime telephone number including the area code

Number of people in your household: Adults ☐ + Children ☐ = Total ☐

How did you hear about the CARE program? ☐ TV ☐ Radio ☐ Newspaper ☐ website ☐ Game app ad ☐ friend/coworker ☐ other

☐ I am currently on a fixed income and receive income or benefits from one or more of the following: pensions, Social Security, SSP or SSDI, interest/dividends from retirement accounts, Medicaid/Medi-Cal (age 65 and over) or SSI.

CARE Program Guidelines

The chart below illustrates monthly gross income levels that qualify for the CARE program. Look at the income allowable for the number of people in your household.

- The Pacific Power bill must be in your name.
- You must live at the address where the discount will be received.
- You may not be claimed as a dependent on another person's income tax return other than your spouse.
- Your household must meet the program income guidelines described on this application.
- Applicants must add all sources of the household's combined income to determine eligibility. These sources include wages and salaries, interest and dividends from savings accounts/stocks/bonds/retirement accounts, unemployment benefits, rental and royalty income, school grants and scholarships, profit from self-employment, disability payments, workers compensation, Social Security (SSI, SSP), pensions, insurance and legal settlements, Temporary Aid for Needy Families (TANF), Aid to Families with Dependent Children (AFDC), food stamps, child support, spousal support, cash and other income.

INCOME QUALIFICATION LEVELS

Households with incomes no greater than the amounts shown below may qualify for CARE:

Household size	Monthly gross income at or below:	Annual income at or below:
1-2	$2,818	$33,820
3	$3,555	$42,660
4	$4,291	$51,500
5	$5,028	$60,340
6	$5,765	$69,180
7	$6,501	$78,020
8	$7,238	$86,860
For each additional person add:	$736	$8,840

Please read carefully and sign below.

I state that my total combined household income is no greater than the amount shown above for the number of members in my household. I agree to provide proof of income if asked. I agree to inform Pacific Power if my income no longer qualifies and I may be required to pay back CARE benefits received. I understand that Pacific Power can share my information with other utilities or agencies to enroll me in their assistance programs.*

X _____
Pacific Power Customer Signature

_____
Date

PACIFIC POWER
POWERING YOUR GREATNESS

**A random sample of CARE participants will be required to provide proof of income.*