Rural Resources Energy Assistance
956 S. Main St. Colville, WA 99114
(509) 685-6000

Rural Resources Energy Assistance Information

Low Income Energy Assistance Program (LIHEAP) is a federally funded program, the purpose of which is to assist qualified, low income households in meeting their home heating needs.

The program can provide a single grant, one time per year, provided funding is available. The grant is a subsidy, and is not intended to pay all winter heating costs. **Pre-applications will be accepted beginning October 3, 2016.**

Applicants will be seen by appointment only, on a "first come, first served" basis. **Appointments for the first 30 days of this energy season will be reserved for those households that include members who meet the following priorities: seniors, disabled persons or have children age 5 and under.** Please mark the priority boxes on the pre-application form where applicable.

Appointments will begin November 1st and continue until funding is exhausted, usually the following spring. If you are scheduled for an appointment, you will be notified of your appointment by mail 1 to 2 weeks in advance. You may request a phone appointment or in-person appointment at our Colville office.

Many households will not receive appointments until late winter or even the following spring, so plan ahead to meet your own home heating needs as much as possible. Please be aware that not all eligible clients will be scheduled for an appointment. Unfortunately, funding often runs out before all applicants can be served.

IMPORTANT INFORMATION ABOUT YOUR APPOINTMENT

An appointment is not a promise of assistance. All information must be verified and complete, and grants are dependent on available funding at the time of processing.

A list of required documents will be mailed with your appointment notification. **All available documents must be returned prior to your appointment date.** Your appointment may be rescheduled if you fail to submit all available documents before your scheduled appointment.

NOTE: After your interview, you may receive a **To-Do List**, requesting signatures, additional documentation and/or information about your household. **You must return requested documents by the due date or you will be denied assistance.** In the past we have been flexible in regards to paperwork due dates; however, due to new rules and regulations, deadlines are final and exceptions can no longer be made.

OCTOBER 2016 – SEPTEMBER 2017
ENERGY ASSISTANCE PRE-APPLICATION FORM
STEVENS, FERRY, PEND OREILLE, AND LINCOLN COUNTIES

You must continue to pay your energy bills.
Applying does not guarantee eligibility or assistance.

PLEASE NOTE: WE SERVE ON A FIRST COME, FIRST SERVED BASIS BY APPOINTMENT. Return this application **IMMEDIATELY.** This form is used to obtain information prior to an interview in an effort to expedite the application process. You will be **contacted by MAIL** of an appointment if we are able to provide assistance.

FILL IN ALL THREE PAGES OF THE PRE-APPLICATION

PLEASE PRINT NEATLY

County: ❑ Stevens ❑ Ferry ❑ Pend Oreille ❑ Lincoln	❑Interested in Weatherization ❑Tribal Member ❑Receive Food Stamps ❑Received Energy Assistance last year	**Utility Account Number** ❑City of Chewelah ❑Avista ❑Ferry CO PUD ❑Inland Power ❑Pend Oreille PUD ❑Off Grid	**FUEL VENDOR** (Pellets, Propane, or Oil) **ACCT#**

***Primary Applicant:** _____
(Last Name) (First Name) (Middle Initial)

***Residence Address:** _____

City, State, Zip: _____

Mailing Address: _____
(If different)

City, State, Zip: _____

Phone Number:	**Message Phone:**	**E-Mail:**	**Lived at Residence:** **Years:** **Months:**

***Housing Status:** 1 ❑Own/buy 2 ❑Subsidized 3 ❑Rental 4 ❑Roomer/Boarder 5 ❑Temp Housing	***Housing Type:** 1 ❑1-3 Family 2 ❑4+ Family 3 ❑Hi-Rise 4 ❑Mobile 5 ❑ RV	***Income/Benefits:** ❑SSI ❑Earned Income ❑TANF ❑Pension ❑GA ❑Self Employed ❑VA ❑Child Support ❑Soc. Sec. ❑Unemployment ❑Military ❑Other	***Total Number of People in the Household:**
Cost per Month: $	**Number of Bedrooms:**		***Household's Total Monthly Income:** $

Priority Groups **Check all that apply to your household:** **Senior Citizens (60+):** ❑Yes ❑No **Disabled:** ❑Yes ❑No **Children 5 and under:** ❑Yes ❑No	*** Primary Heat Source** 1 ❑Electric 2 ❑Natural Gas 3 ❑Propane 4 ❑Oil 5 ❑Wood 6 ❑Coal	**Allowable Deductions** (Must Provide Proof) **Monthly Medicare Premiums** $_____ *(Paid out of pocket for supplemental insurance NOT previously deducted from Social Security.)* **Child Support Paid** $_____ **Spousal Support Paid** $_____	**FILL OUT OTHER SIDE**  **FOR AGENCY USE ONLY DO NOT WRITE IN THIS AREA**

Washington State Department of Commerce, Low Income Home Energy Assistance Program (LIHEAP)

Household Member Information Form (10/2014)

* Last Name	* First Name	MI	* SSN *(required if primary)* ___ ___ ___ - ___ ___ - ___ ___ ___ ___	* DOB ___ ___ / ___ ___ / ___ ___ ___ ___

* Relation to Primary	* Gender / Ethnicity	Race	Education (24 Years or Older)	Disabled / Military Veteran / Health Insurance
❑ Self ❑ Spouse ❑ Partner ❑ Child ❑ Other Relative ❑ Other Non-Relative	* Gender ❑ Male ❑ Female **Ethnicity** ❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Multi-Race ❑ Other	❑ 0-8 ❑ 9-12 Non-Graduate ❑ High School Graduate/GED ❑ 12+ Some Post-Secondary ❑ 2 or 4 Year College Graduate	**Disabled** ❑ Yes ❑ No **Military Veteran** ❑ Yes ❑ No **Health Insurance** ❑ Yes ❑ No

* Last Name	* First Name	MI	* SSN *(required if secondary)* ___ ___ ___ - ___ ___ - ___ ___ ___ ___	* DOB ___ ___ / ___ ___ / ___ ___ ___ ___

* Relation to Primary	* Gender / Ethnicity	Race	Education (24 Years or Older)	Disabled / Military Veteran / Health Insurance
❑ Spouse ❑ Partner ❑ Child ❑ Other Relative ❑ Other Non-Relative **Secondary Applicant** ❑ Yes ❑ No	* Gender ❑ Male ❑ Female **Ethnicity** ❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Multi-Race ❑ Other	❑ 0-8 ❑ 9-12 Non-Graduate ❑ High School Graduate/GED ❑ 12+ Some Post-Secondary ❑ 2 or 4 Year College Graduate	**Disabled** ❑ Yes ❑ No **Military Veteran** ❑ Yes ❑ No **Health Insurance** ❑ Yes ❑ No

* Last Name	* First Name	MI	SSN ___ ___ ___ - ___ ___ - ___ ___ ___ ___	* DOB ___ ___ / ___ ___ / ___ ___ ___ ___

* Relation to Primary	* Gender / Ethnicity	Race	Education (24 Years or Older)	Disabled / Military Veteran / Health Insurance
❑ Spouse ❑ Partner ❑ Child ❑ Other Relative ❑ Other Non-Relative	* Gender ❑ Male ❑ Female **Ethnicity** ❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Multi-Race ❑ Other	❑ 0-8 ❑ 9-12 Non-Graduate ❑ High School Graduate/GED ❑ 12+ Some Post-Secondary ❑ 2 or 4 Year College Graduate	**Disabled** ❑ Yes ❑ No **Military Veteran** ❑ Yes ❑ No **Health Insurance** ❑ Yes ❑ No

* Last Name	* First Name	MI	SSN ___ ___ ___ - ___ ___ - ___ ___ ___ ___	* DOB ___ ___ / ___ ___ / ___ ___ ___ ___

* Relation to Primary	* Gender / Ethnicity	Race	Education (24 Years or Older)	Disabled / Military Veteran / Health Insurance
❑ Spouse ❑ Partner ❑ Child ❑ Other Relative ❑ Other Non-Relative	* Gender ❑ Male ❑ Female **Ethnicity** ❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Multi-Race ❑ Other	❑ 0-8 ❑ 9-12 Non-Graduate ❑ High School Graduate/GED ❑ 12+ Some Post-Secondary ❑ 2 or 4 Year College Graduate	**Disabled** ❑ Yes ❑ No **Military Veteran** ❑ Yes ❑ No **Health Insurance** ❑ Yes ❑ No

* Last Name	* First Name	MI	SSN ___ ___ ___ - ___ ___ - ___ ___ ___ ___	* DOB ___ ___ / ___ ___ / ___ ___ ___ ___

* Relation to Primary	* Gender / Ethnicity	Race	Education (24 Years or Older)	Disabled / Military Veteran / Health Insurance
❑ Spouse ❑ Partner ❑ Child ❑ Other Relative ❑ Other Non-Relative	* Gender ❑ Male ❑ Female **Ethnicity** ❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Multi-Race ❑ Other	❑ 0-8 ❑ 9-12 Non-Graduate ❑ High School Graduate/GED ❑ 12+ Some Post-Secondary ❑ 2 or 4 Year College Graduate	**Disabled** ❑ Yes ❑ No **Military Veteran** ❑ Yes ❑ No **Health Insurance** ❑ Yes ❑ No

* Last Name	* First Name	MI	SSN ___ ___ ___ - ___ ___ - ___ ___ ___ ___	* DOB ___ ___ / ___ ___ / ___ ___ ___ ___

* Relation to Primary	* Gender / Ethnicity	Race	Education (24 Years or Older)	Disabled / Military Veteran / Health Insurance
❑ Spouse ❑ Partner ❑ Child ❑ Other Relative ❑ Other Non-Relative	* Gender ❑ Male ❑ Female **Ethnicity** ❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Multi-Race ❑ Other	❑ 0-8 ❑ 9-12 Non-Graduate ❑ High School Graduate/GED ❑ 12+ Some Post-Secondary ❑ 2 or 4 Year College Graduate	**Disabled** ❑ Yes ❑ No **Military Veteran** ❑ Yes ❑ No **Health Insurance** ❑ Yes ❑ No

Note: All fields designated with an (*) are required information. SSN's for the primary and secondary applicants are also required.

RETURN TO:
Rural Resources Community Action
956 S. Main, Suite A
COLVILLE, WA 99114 (509) 685-6000

PLEASE NOTE: APPOINTMENTS ARE SCHEDULED ON A FIRST COME, FIRST SERVED BASIS.
Return this application **IMMEDIATELY** in the enclosed envelope. **(Postage is required).**

AUTHORIZATION FOR INFORMATION RELEASE
October 2016 through September 2017

By signing below I authorize Rural Resources Energy Programs staff to submit information to or request information from governmental agencies and financial institutions, including its own programs and divisions, regarding my income, and other pertinent household information for the purpose of eligibility, verification, and processing of my Energy Assistance application. I certify that the information contained in this application is complete and accurate to the best of my knowledge. I understand that if I knowingly give false information, which results in assistance for which I am not eligible, I am subject to criminal prosecution.

*****Signatures required for each household member 18 years and older*****

PLEASE PRINT Name _____

_____
Signature Date

PLEASE PRINT Name _____

_____
Signature Date

PLEASE PRINT Name _____

_____
Signature Date

PLEASE PRINT Name _____

_____
Signature Date

LIHEAP Program Income Limits

Household Members	Net Monthly Income Limit 125% of Poverty
1	$1,238
2	$1,669
3	$2,100
4	$2,531
5	$2,963
6	$3,394

If you are 60+ years old, an Avista customer, and below the LIRAP Seniors income limits, then you may qualify for the LIRAP Senior grant. Please fill out the application and return it to Rural Resources.

LIRAP Seniors Income Limits

Household Members	Net Monthly Income Limit 200% of Poverty
1	$1,980
2	$2,670
3	$3,360
4	$4,050
5	$4,740

All household members, over 18, that receive assistance from DSHS (food stamps, TANF, etc.) must fill out this form and return it with the application.

Washington State Department of Social & Health Services

CONSENT

NOTICE TO CLIENTS: The Department of Social and Health Services (DSHS) can help you better if we are able to work with other agencies and professionals that know you and your family. By signing this form, you are giving permission for DSHS and the agencies and individuals listed below to use and share confidential information about you. DSHS cannot refuse you benefits if you do not sign this form unless your consent is needed to determine your eligibility. If you do not sign this form, DSHS may still share information about you to the extent allowed by law. If you have questions about how DSHS shares client confidential information or your privacy rights, please consult the DSHS Notice of Privacy Practices or ask the person giving you this form.

CLIENT IDENTIFICATION:

NAME	DATE OF BIRTH	IDENTIFICATION NUMBER

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER (INCLUDE AREA CODE)	OTHER INFORMATION

CONSENT:

I consent to the use of confidential information about me within DSHS to plan, provide, and coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. I further grant permission to DSHS and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer data transfer, mail, or hand delivery.

Please check all below who are included in this consent in addition to DSHS and identify them by name and address:

- ☐ Health care providers: _____
- ☐ Mental health care providers: _____
- ☐ Chemical dependency service providers: _____
- ☐ Other DSHS contracted providers: _____
- ☐ Housing programs: _____
- ☐ School districts or colleges: _____
- ☐ Department of Corrections: _____
- ☐ Employment Security Department and its employment partners: _____
- ☐ Social Security Administration or other federal agency: _____
- ☐ See attached list
- ☑ Other: Rural Resources Community Action - Energy Assistance Program

I authorize and consent to sharing the following records and information (check all that apply):

- ☐ All my client records
- ☐ Records on attached list
- ☑ Only the following records
  - ☑ Family, social and employment history
  - ☐ Payment records
  - ☐ Other (list):
  - ☐ Health care information
  - ☐ Individual assessments
  - ☐ Treatment or care plans
  - ☐ School, education, and training

PLEASE NOTE: If your client records include any of the following information, you must also complete this section to include these records.

I give my permission to disclose the following records (check all that apply):

☐ Mental health ☐ HIV/AIDS and STD test results, diagnosis, or treatment ☐ Chemical Dependency (CD) services

- **This consent is valid for ☑ one year ☐ as long as DSHS needs records, or ☐ until _____ (date or event).**
- **I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.**
- **I understand that records shared under this consent may no longer be protected under the laws that apply to DSHS.**
- **A copy of this form is valid to give my permission to share records.**

SIGNATURE	DATE	AGENCY CONTACT/WITNESS SIGNATURE	DATE

PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF APPLICABLE)	TELEPHONE NUMBER (INCLUDE AREA CODE)	DATE

If I am not the subject of the records, I am authorized to sign because I am the: (attach proof of authority)

☐ Parent ☐ Legal Guardian (attach court order) ☐ Personal representative ☐ Other:

NOTICE TO RECIPIENTS OF INFORMATION: **If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission.** If you have received information related to drug or alcohol abuse by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medial or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.