

EightCAP, Inc. Emergency Assistance Application

All information must be completed to ensure timely processing of your application. If all required information and documentation is not provided, processing of the application will be halted until all required information is received.

Name:	Phone:
First Middle Initial Last	Please include message number if applicable

Address:
Street/Road Address Apt. # City State ZIP

County:	Email:
Preferred Choice of Contact (Please check): <input type="checkbox"/> Phone <input type="checkbox"/> Email (Contact will be during our business hours of 8:00-4:30)	

List all household member's names including applicant (First, M.I., Last)	Relationship to Applicant	Date of Birth	Male/ Female	Race	Highest Level of Education	US Citizen?
	Self					<input type="checkbox"/> Y <input type="checkbox"/> N
						<input type="checkbox"/> Y <input type="checkbox"/> N
						<input type="checkbox"/> Y <input type="checkbox"/> N
						<input type="checkbox"/> Y <input type="checkbox"/> N
						<input type="checkbox"/> Y <input type="checkbox"/> N
						<input type="checkbox"/> Y <input type="checkbox"/> N
						<input type="checkbox"/> Y <input type="checkbox"/> N
						<input type="checkbox"/> Y <input type="checkbox"/> N
						<input type="checkbox"/> Y <input type="checkbox"/> N

All Questions Below Must Be Answered

Have you applied for or received energy assistance from any other agency since October 1 st ?	<input type="checkbox"/> Y <input type="checkbox"/> N
<i>If yes, what agency?</i>	
Do you receive services from Department of Health & Human Services (DHHS)?	<input type="checkbox"/> Y <input type="checkbox"/> N
<i>If yes, what services?</i>	
Have you applied at DHHS for this emergency?	<input type="checkbox"/> Y <input type="checkbox"/> N
<i>If yes, how much is DHHS assisting with your emergency? Please attach decision notice.</i>	
Have you received assistance from EightCAP, Inc. in the past 12 months?	<input type="checkbox"/> Y <input type="checkbox"/> N
<i>If yes, who was the applicant?</i>	
Have you received a shut-off notice for this emergency?	<input type="checkbox"/> Y <input type="checkbox"/> N
Has your heat been shut off/have you ran out of fuel?	<input type="checkbox"/> Y <input type="checkbox"/> N
Have you received a Home Heating Credit in the past 6 months?	<input type="checkbox"/> Y <input type="checkbox"/> N
<i>If yes, when and how much did you receive?</i>	
Does this household use electric to run heat source (ex. Furnace, Forced Air, Fan, etc.)	<input type="checkbox"/> Y <input type="checkbox"/> N
Are you licensed to manufacture medical marijuana?	<input type="checkbox"/> Y <input type="checkbox"/> N
<i>If yes, do you manufacture marijuana on your premises?</i>	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you own (O) or rent (R) your home?	<input type="checkbox"/> O <input type="checkbox"/> R
<i>If renting, is your rent subsidized by the State or Federal Government?</i>	<input type="checkbox"/> Y <input type="checkbox"/> N
Is any member of the household a veteran?	<input type="checkbox"/> Y <input type="checkbox"/> N
Is any member of the household disabled and receiving benefits?	<input type="checkbox"/> Y <input type="checkbox"/> N
Is any member of the household pregnant?	<input type="checkbox"/> Y <input type="checkbox"/> N
Are you an EightCAP, Inc. employee?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you have a child enrolled in Head Start or GSRP?	<input type="checkbox"/> Y <input type="checkbox"/> N
<i>If yes, what center?</i>	

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What is your emergency need? (Check all that apply)

Electric Heat Other, explain _____

For Housing Assistance, please call our Housing Hotline at (866) 754-9315 x 3335

How do you heat your home? Natural Gas Propane Fuel Oil Electric Wood Pellets Other

Please provide vendor information below.

Electric	Company Name:	Account #
	Name on Account:	
Natural Gas	Company Name:	Account #
	Name on Account:	
Deliverable Fuel <small>(Propane, Fuel Oil, Wood, Pellets, Corn, etc.)</small>	Company Name:	Account #
	Name on Account:	
	Phone # of Company:	What % is tank at?
	Is tank metered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Is this your only heat source?
	Do you have a back bill? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other	Describe:	
	Provider Name:	Phone #:

Please check one answer only for each question

What is your employment situation?	<input type="checkbox"/> Permanent employment <input type="checkbox"/> Temporary/Seasonal Employment <input type="checkbox"/> Part-time Employment <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed with work skills <input type="checkbox"/> Unemployed without work skills
Do you have transportation?	<input type="checkbox"/> Immediate, reliable, safe access to transportation <input type="checkbox"/> Limited/unreliable access transportation <input type="checkbox"/> No transportation
Do you have child care provided?	<input type="checkbox"/> No children in home/or child does not need care <input type="checkbox"/> Child care is provided by licensed provider <input type="checkbox"/> Family member provides child care
Do you have enough food?	<input type="checkbox"/> Family able to meet basic food need <input type="checkbox"/> Receiving food assistance <input type="checkbox"/> Receiving assistance but occasionally uses food bank <input type="checkbox"/> Unable to provide basic food needs
Do you have health insurance?	<input type="checkbox"/> All household members are covered <input type="checkbox"/> Some household members are covered <input type="checkbox"/> No household members are covered
Are you able to meet clothing needs?	<input type="checkbox"/> Family is able to afford basic needs <input type="checkbox"/> Family is able to afford some clothing to meet basic needs <input type="checkbox"/> Family is unable to meet basic needs
Are you disabled?	<input type="checkbox"/> No senior/disabled adult in home <input type="checkbox"/> Can live independently without assistance <input type="checkbox"/> Can live independently with some assistance

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Please check all sources of income that your household has received in the past 90 days.

Does any member of your household have income? Yes No

If yes, check all that apply and attach proof of income for the past 90 days.

<input type="checkbox"/> Social Security	<input type="checkbox"/> Disability Benefits	<input type="checkbox"/> Employment/Earned Income
<input type="checkbox"/> Supplemental Security Income (SSI)	<input type="checkbox"/> Self-Employment Income	<input type="checkbox"/> Worker's Compensation
<input type="checkbox"/> Pension/Retirement Benefits	<input type="checkbox"/> Unemployment	<input type="checkbox"/> Money from Family/Friends
<input type="checkbox"/> Veteran's Benefits/Military Allotments	<input type="checkbox"/> Rental Income	<input type="checkbox"/> Child Support
<input type="checkbox"/> Other (ex: Adoption Subsidy, Lottery Winnings, State Supplemental Income, Investment Income, Cash from working, etc. Please list: _____)		

Income Verification

Household Member with Income	Type of Income (If employed, name of employer)	How Often Received (Weekly, bi-weekly, monthly, etc.)	Gross Monthly Income (Amount before taxes and expenses)
Total Gross Income:			\$

Has there been any, or do you expect any changes in your household's income in the next 30 days? (Please provide verification from employer of this change.)

- No
 Yes, please explain.

Eligible Income Expenses

Has your household paid any of the following expenses in the past 90 days? Yes No

If yes, check all that apply and attach documentation proof.

<input type="checkbox"/> Health Insurance Premiums	\$ Amount	<input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> monthly
<input type="checkbox"/> Court-ordered Child Support (Amount you paid)	\$ Amount	<input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> monthly
<input type="checkbox"/> Out-of pocket Childcare Cost (Amount you paid – not DHHS)	\$ Amount	<input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> monthly
<input type="checkbox"/> Deductions required by employer (union dues, uniforms, etc.)	\$ Amount	<input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> monthly

I, "applicant," give EightCAP, Inc. consent to release, obtain and share all pertinent identifying and non-confidential social, medical and other information about myself and information I have provided about additional family members that will allow me and my family to benefit from services offered. In granting such permission, I understand such information will remain confidential and will only be used for my benefit or to benefit other members of my family. Only authorized personnel will share client information needed for service delivery, to track demographic trends, service patterns and the client outcomes achieved. I release EightCAP, Inc. and its staff from any legal liability for disclosing or acquiring information that I have permitted by signing this form. Unless I make a formal request to EightCAP, Inc. that I no longer want to participate in the services offered, this release will remain in force for 3 years from today. The statements made by me on this consent form are true, correct and complete to the best of knowledge.

CAA, its agent, partners and funding sources do not discriminate on the basis of race, color, sex, age, religion, national origin, disability or marital status. If you, the applicant, feel you were treated unfairly or denied service(s), please notify the agency in your county of residence to appeal and request a fair hearing. Your application will be properly reviewed to determine eligibility based on the required documentation provided.

The Department of Health and Human Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc. under the Americans with Disabilities Act, you are invited to make your needs known to a DHHS office in your county.

I hereby make application for the Michigan Energy Assistance Program (MEAP). I understand there may be a delay in processing if there is missing information. The MEAP crisis season runs from November 1 through May 31 therefore emergency assistance may not be available June 1 through October 31. I understand I have (7) seven calendar days to provide all verifications requested and failure to provide the above information may result in denial of my application. I understand giving false information can result in referral to the prosecutor for fraud. I understand my application may be one of those chosen for a complete investigation. An agency or department representative may call me at my home and may contact other people in order to verify my eligibility for assistance. I authorize my energy company to release by phone, fax, email or their computer web site all available information about my account. UNDER PENALTIES OF PERJURY, I SWEAR OR AFFIRM THAT THIS APPLICATION HAS BEEN EXAMINED BY, OR READ TO, ME. IF I AM A THIRD PARTY APPLYING ON BEHALF OF ANOTHER PERSON, I SWEAR THAT THIS APPLICATION HAS BEEN EXAMINED BY, OR READ TO THE APPLICANT AND TO THE BEST OF MY KNOWLEDGE, THE FACTS ARE TRUE AND COMPLETE.

Signature of Applicant: _____ **Date:** _____

Signature of Staff: _____ **Date:** _____

Are there any other services you need that we can make a referral for? If yes, please explain below:

This section to be completed by EightCAP Community Services Staff Only				
Heat/Utility Provider	Date Application Received	Date Completed Application Received	Client Portion & Date Given	Date & Time of Appointment

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RECAP of Required Items Needed (If required information is not submitted, processing of this application will be delayed until information is received):

- Completed Application with Signature and Date
- Proof of All Household Income (past 90 days)
- Current phone number to verify your assistance
- DHHS Decision Notice (if applicable)
- Pages 3 – 7 of this application
- All Supporting Documentation (income, invoices, etc.)

You MUST bring actual Social Security Card with current ID (acceptable forms are listed on page 2) for Head of Household to appointment.

EightCAP, Inc. requires 10 days for processing a completed application. If there are any missing required documents, the application will be halted until all needed information is received. This will delay the emergency assistance decision.

Send completed application (pages 3 – 7) and required documentation to your nearest EightCAP office listed below.

Gratiot County

EightCAP, Inc.
Attention: Community Services
525 N. State Street, Suite 2
Alma, MI 48801
Email: tammied@8cap.org
Phone: (989) 463-5693
Fax: (989) 463-6872

Ionia County

EightCAP, Inc.
Attention: Community Services
5827 Orleans Road
Orleans, MI 48865
Email: julieh@8cap.org
Phone: (616) 208-1580
Fax: (616) 208-1574

Isabella County

EightCAP, Inc.
Attention: Community Services
310 W. Michigan Street
Mt. Pleasant, MI 48858
Email: triciad@8cap.org
Phone: (989) 772-0110
Fax: (989) 775-3907

Montcalm County

EightCAP, Inc.
Attention: Community Services
Mailing Address: 904 Oak Drive
Physical Address: 906 Oak Drive
Greenville, MI 48838
Email: jillp@8cap.org
Phone: (616) 754-9315
Fax: (616) 754-9310