



Ways to Apply for LIHEAP

1. **Apply Online – Recommended for Faster Processing** Submit your application through our online portal www.caliheapapply.com for quicker assistance.
2. **Download & Mail Your Application**
 - Visit the CAPOC website to download and print the application.
 - Fill out the form and attach the *required documents.
 - Mail the completed application to the address below.
 - ***Do not send original documents—only copies.***
3. **Visit Our Office**
 - Pick up an application in person.
 - Complete the forms and attach the *required documents.
 - Drop off your application at the reception area.
4. **Fax Your Application** Instead of mailing, you may fax the completed application and *required documents.

*Required Documents for LIHEAP Application

1. **Current Utility Bills**
 - Provide copies of your electric and gas bills (all pages).
 - Bills must cover at least 22 days.
 - If utilities are included in rent, submit a statement showing electric/gas charges.
2. **Proof of Income (Last 30 Days) for All Household Members**
 - Paystubs (last 4 weeks)
 - CalFresh/CalWORKS: Verification of Benefits letter (current month/year)
 - SSI/SSA: Most current award letter or bank statement showing deposit
 - Pension: Most current award letter (*bank statements not accepted*)
 - Cash Income: Complete Form 43B - Certification of Income & Expenses (included in application)
 - Unemployment Benefits: EDD statement (must cover 4 consecutive weeks)
3. **U.S Government-Issued Photo ID**
 - Provide a valid photo ID for verification.
4. **Other documents may be requested by the processing staff or management upon reviewing your application.**

Energy and Environmental Services Department

11870 Monarch St., Garden Grove, CA 92841

Tel. (714) 839-6199 / Fax. (714) 839-2817 / www.capoc.org



Community Action Partnership of Orange County (CAP OC), Energy and Environmental Services Department oversees administration of the Low-Income Home Energy Assistance Program (LIHEAP) and the Department of Energy's Weatherization Assistance Program (DOE WAP). These programs are funded by the United States Department of Health and Human Services, Department of Energy Region IX, and the California Department of Community Services and Development (CSD). The programs are designed to assist eligible low-income households to manage and meet their immediate home heating and/or cooling needs. In addition, LIHEAP provides financial assistance to offset heating and/or cooling costs and helps to improve household energy efficiency.

If you have a disability or need help with this application, you may request assistance from an agency representative, and someone will help you.

How do I apply?

- Complete the pages included in this application and include all required documents
 - Print clearly utilizing an ink pen, do **not** use a pencil.
 - If you make an error, do **not** use white-out. Simply draw a line through the error, initial it, and enter the correct information.
 - Remember to sign and date your application.
 - A checklist of all mandatory documents is included to assist you in the application process. Incomplete and unsigned applications will delay the process of your application.
- Give the application to CAP OC in person, by mail or by fax (contact info on next page)

Who gets priority?

In accordance with federal law, our department establishes a priority rating system once we reach a financial budget benchmark. Benefits are calculated based on your household's out-of-pocket energy cost versus household income and a point system.

How long will it take?

It may take up to 60 days until your utility assistance application has been processed. It is your responsibility to continue to pay and/or make payment arrangements with your utility company until eligibility is determined. We do not guarantee your benefit will be processed and paid before the date of the bill is due.

CAP OC will send you a letter to let you know if your household is approved or denied and HEAP benefits.

Department of Community Services and Development
Energy Intake Form
CSD 43 (05/2025)
Official Use Only:
Priority Points
A.C.C.

Agency:	Intake Initials:	Intake Date:	Eligibility Cert Date
First name		Middle Initial	Last Name
			Date of Birth MM/DD/YY
SERVICE ADDRESS – Address where you live (this <i>cannot</i> be a P.O. Box)			
Service Address			Unit Number
Service City		Service County	Service State
Service Zip Code			
Have you lived at this residence during each of the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is your service address the same as mailing address? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you own or rent your home? <input type="checkbox"/> Own <input type="checkbox"/> Rent			
Mailing Address			Unit Number
Mailing City		Mailing County	Mailing State
Mailing Zip Code			
Social Security Number (SSN):		Home Phone ()	
Mobile Phone ()		Do you agree to opt in to receive text messages? <input type="checkbox"/> Yes <input type="checkbox"/> No	
E-mail Address:			

PEOPLE LIVING IN HOUSEHOLD Enter the total number of people living in the household,  		INCOME Enter the total number of people who receive income  
<i>Demographics: Enter the number of people in the household who are:</i>		<i>Enter the total gross monthly income for all people living in the household:</i>
Ages 0 – 2 Years		TANF / CalWORKs
Ages 3 - 5 years		SSI / SSP
Ages 6 - 18 years		SSA / SSDI
Ages 19 - 59		Paycheck(s)
Ages 60 and older		Interest
Disabled		Pension
Native American		Other
Seasonal or Migrant Farmworker		Total Monthly Income

HOUSEHOLD MEMBERS

ENTER THE INFORMATION BELOW FOR ALL HOUSEHOLD MEMBERS.

If you have more than 6 people in your household, please list the information on a separate piece of paper.

APPLICANT (HOUSEHOLD MEMBER 1)

First Name	M.I.	Last Name	Relationship to Applicant <i>Self</i>
Date of Birth:	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"/> Multi-Race <input type="checkbox"/> Other <input type="checkbox"/> Unknown/Decline to State		Hispanic/ Latino/Spanish? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/Decline to State
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown/Decline to State			
Have you served or are you an immediate family member of someone who served in the United States military?		I consent to this agency, and CSD, transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I or my family member may be eligible. I understand that this consent is valid for 12 months.	
<input type="checkbox"/> Yes, I have Served <input type="checkbox"/> Yes, I am the Spouse, legal partner, parent, or child of a person who served in the United States military <input type="checkbox"/> No <input type="checkbox"/> Decline to State		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Amount of Gross Monthly Income (before taxes):	Source of Income:		

HOUSEHOLD MEMBER 2

First Name	M.I.	Last Name	Relationship to Applicant
Date of Birth:	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"/> Multi-Race <input type="checkbox"/> Other <input type="checkbox"/> Unknown/Decline to State		Hispanic/ Latino/Spanish? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/Decline to State
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown/Decline to State			
Amount of Gross Monthly Income (before taxes):		Source of Income:	

HOUSEHOLD MEMBER 3

First Name	M.I.	Last Name	Relationship to Applicant
Date of Birth:	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"/> Multi-Race <input type="checkbox"/> Other <input type="checkbox"/> Unknown/Decline to State		Hispanic/ Latino/Spanish? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/Decline to State
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown/Decline to State			
Amount of Gross Monthly Income (before taxes):		Source of Income:	

HOUSEHOLD MEMBER 4

First Name	M.I.	Last Name	Relationship to Applicant
Date of Birth:	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"/> Multi-Race <input type="checkbox"/> Other <input type="checkbox"/> Unknown/Decline to State		Hispanic/ Latino/Spanish? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/Decline to State
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown/Decline to State			
Amount of Gross Monthly Income (before taxes):		Source of Income:	

HOUSEHOLD MEMBER 5

First Name	M.I.	Last Name	Relationship to Applicant
Date of Birth:	Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian		Hispanic/ Latino/Spanish?
Sex: <input type="checkbox"/> Female	<input type="checkbox"/> Black or African American		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Male	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White		<input type="checkbox"/> Unknown/Decline to State
<input type="checkbox"/> Unknown/Decline to State	<input type="checkbox"/> Multi-Race <input type="checkbox"/> Other <input type="checkbox"/> Unknown/Decline to State		
Amount of Gross Monthly Income (before taxes):		Source of Income:	

HOUSEHOLD MEMBER 6

First Name	M.I.	Last Name	Relationship to Applicant
Date of Birth:	Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian		Hispanic/ Latino/Spanish?
Sex: <input type="checkbox"/> Female	<input type="checkbox"/> Black or African American		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Male	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White		<input type="checkbox"/> Unknown/Decline to State
<input type="checkbox"/> Unknown/Decline to State	<input type="checkbox"/> Multi-Race <input type="checkbox"/> Other <input type="checkbox"/> Unknown/Decline to State		
Amount of Gross Monthly Income (before taxes):		Source of Income:	

Are you or someone in your household CURRENTLY receiving CalFresh (Food Stamps)? Yes No

PAY BILL

To which energy bill (CHOOSE ONLY ONE) do you want the LIHEAP benefit to be applied? (Attach complete copy of most recent bill or receipt)

Natural Gas Electricity Wood Propane Fuel Oil Kerosene Manufactured log Pellets Other Fuel

Enter the energy company and account number:

Company Name: _____ Account #: _____

Is your utility service shut-off? Yes No

Do you have a past due notice? Yes No

Are your utilities included in rent or submetered? Yes No

Are your utilities all electric? Yes No

Is your Natural Gas Company the same as your Electric Company? Yes No

WOOD, PROPANE or FUEL OIL SERVICE (WPO)

Are you currently out of fuel? (Wood, Propane, Oil, Kerosene, Other Fuels) Yes No N/A

List the approximate number of days until you run out of fuel (Wood, Propane, Oil, Kerosene, Other Fuels).

Number of Days: _____ N/A

ENERGY INFORMATION

The questions below are **MANDATORY**. Please check all energy sources used to heat your home.

A copy of **all** recent energy bills and/or receipts for any home energy cost **must** be provided.

NOTE: A copy of an electric bill must be included even if you do not use electricity to heat your home.

What is the main fuel used to HEAT your home? One main heating source **MUST** be checked.

Natural Gas Electricity Wood Propane Fuel Oil Kerosene Manufactured log Pellets Other Fuel

In addition to your main heating source, do you ever use any of the following to heat your home (you can select more than one):

Natural Gas Electricity Wood Propane Fuel Oil Kerosene Manufactured log Pellets Other Fuel N/A

Are you the account holder: Electric Bill Yes No Natural Gas Bill Yes No

The information on this application will be used to determine and verify my eligibility for assistance. By signing below, I give my consent (permission) to CSD, its contractors, consultants, other federal or state agencies (CSD Partners) and to my utility company and its contractors, to share information about my household's utility account, energy usage and/or other information needed to provide services and benefits to me as described at the end of the form. My consent shall be effective for the period beginning 24 months prior to, and continuing for 36 months after, the date signed below. 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. If applicable, I hereby authorize installation of weatherization measures to my residence at no cost to me. 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.

X		
* * * APPLICANT'S SIGNATURE * * *		Date

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.

APPLICANT: DO NOT FILL OUT THE INFORMATION BELOW. THIS SECTION IS FOR OFFICIAL USE ONLY.

Utility Assistance being provided under which program → HEAP Fast Track HEAP WPO ECIP WPO

Base Benefit \$ _____ **Supplement \$** _____ **Total Benefit \$** _____

Total Energy Cost \$ _____ **Energy Burden** _____

Energy Services Restored after disconnection: Yes No Disconnection of Energy Services prevented: Yes No

Home Referred for WX: Home Already Weatherized:

Department of Community Services and Development

Account Holder Authorization and Consent Form

CSD Form 081 (Rev. 12/17)

ACCOUNT HOLDER NAME(S) AND MAILING ADDRESS

Account Holder's Full Name		
Account Holder's mailing address (Street)		Unit Number (if any)
(City)	State	Zip Code
Is the utility service address the same as the account holder's mailing address? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Full Name of Applicant for Benefits (from Form 43)		
Utility Service Address (Street)		Unit Number (if any)
(City)	State	Zip Code

UTILITY INFORMATION

Please enter your utility company name and service account number below (you can find the account number on your bill). If different companies provide your electricity and gas services, please enter the name and account number for both utilities.

Name of Utility Company	Service Account Number
Name of Utility Company (if you have a second Utility Company)	Service Account Number

AUTHORIZATION AND CONSENT

By signing this form, you (Account Holder) give your authorization and consent (permission) to CSD, its contractors, consultants, other federal or state agencies (CSD Partners) and to your utility company and its contractors, to share information about your property's utility account, meter usage and energy consumption data, and other information as needed for the period beginning 24 months prior to, and continuing for 36 months after, the date signed below. The information you authorize us to obtain and share will be used for the purposes of evaluating home energy usage of program beneficiaries so that CSD can: a) measure the effectiveness of the services we provide by determining how much your utility bills are reduced and how much our services reduce carbon emissions (air pollution), and b) report these results to federal and state authorities that fund and oversee energy assistance programs in California. CSD, its contractors, consultants, other federal or state agencies and affiliated programs (CSD Partners), working cooperatively with your utility company and its contractors, use this information to provide services that assist low-income families, such the applicant, to pay their home energy bills and manage those energy needs for the purposes stated in this Authorization.

Signature of Account Holder	Date	Name of CSD Contractor/Partner Organization
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REVOCATION OF AUTHORIZATION AND CONSENT

You agree that your consent shall remain in effect for 36 months from the date you sign this Authorization, unless otherwise revoked by written notice mailed to: CSD Energy & Environmental Services Division, 2389 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833. Revocation will be effective upon receipt, but will not apply to any information shared while this Authorization was valid.

APPLICABLE PROGRAMS

Some of the programs CSD oversees or partners with include:

- CSD Federal Low-Income Home Energy Assistance Program (LIHEAP)
- CSD Federal Department of Energy Weatherization Assistance Program (DOE WAP)
- State Low-Income Weatherization Program (LIWP)
- Department of Housing and Urban Development (HUD) Lead Hazard Control and Healthy Homes Program
- Utility Company Energy Savings Assistance (ESA) Program
- Utility Company California Alternate Rates for Energy (CARE) Program

Department of Community Services and Development

CSD 43B (rev.12/2013)

CERTIFICATION OF INCOME AND EXPENSES

You are being asked to complete this form because you requested assistance, and state that your entire household cannot provide proof of income. The State of California requires the applicant to report all sources of income. This form will help us understand how you are meeting expenses. Please complete the information below:

Name and Address	
Name:	
Address:	

Section 1: Do you have sources of income you forgot to report?		
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? _____

Put Notary stamp below, if needed (DOE only) or have Executive Director Sign here

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:			
<hr/> <hr/> <hr/>			

Signature:	
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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

UTILITIES VERIFICATION STATEMENT FORM

You are being asked to complete this form because your tenant has requested assistance, and stated that their household cannot provide proof of included in rent utility verification. The State of California requires the applicant to report how much of their household income is paid toward energy costs. This is pursuant to the Low-Income Home Energy Assistance Program Reauthorization Act of 1994, Public Law 97-35, as amended. Therefore, in keeping with the intent of Federal Law, landlords and property managers are now being asked to provide, upon request, to HEAP applicants the amount of rent dollars that are spent to pay for heating/cooling costs. This form will help us understand how much of their rent is applied toward utility costs. Please complete the information below:

SECTION I		
First Name	Middle Initial	Last Name
Service Address		Unit Number
Service City	Service State	Service Zip Code

SECTION II				
1. IS THE ABOVE INDIVIDUAL LIVING IN THE PROPERTY AT THE ABOVE ADDRESS?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
2. DO YOU LIVE IN A SEPARATE HOUSEHOLD FROM YOUR TENANT?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
3. DO YOU RECEIVE A SECTION 8 OR RENTAL SUBSIDY ON BEHALF OF HIS TENANT OR FOR THE PROPERTY THIS TENANT LIVES IN? IF YES, PLEASE INDICATE THE MONTHLY AMOUNT \$_____	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
4. WHAT IS THE MONTHLY AMOUNT OF RENT ACTUALLY PAID BY THE TENANT? \$_____				
5. PLEASE CHECK ALL TYPES OF FUEL THAT IS INCLUDED IN THE RENT:	<input type="checkbox"/> NATURAL GAS <input type="checkbox"/> ELECTRIC <input type="checkbox"/> WOOD <input type="checkbox"/> PROPANE <input type="checkbox"/> FUEL OIL <input type="checkbox"/> KEROSENE			
6. PLEASE INDICATE THE MONTHLY AMOUNT OF RENT PAID TOWARDS THE FUEL TYPE(S) LISTED ABOVE:				
TYPE OF FUEL: _____	AMOUNT: \$_____	TYPE OF FUEL: _____	AMOUNT: \$_____	

*If you are unable to determine the actual cost of energy per unit, you can estimate the cost by dividing the total current energy cost on the utility bill by the number of unit's services by that bill.

SECTION III			
<i>Have your landlord complete Section "A" below or tenant can also self certify on Section "B" if unable to obtain landlord's certification. Tenant must provide a brief written hardship detailing the inability to obtain landlord's certification. 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.</i>			
A. LANDLORD CERTIFICATION		B. TENANT SELF CERTIFICATION (INDICATE HARDSHIP BELOW)	
LANDLORD'S NAME		LANDLORD'S NAME	
STREET ADDRESS OR PO BOX NUMBER		STREET ADDRESS OR PO BOX NUMBER	
CITY	STATE	ZIP CODE	
TELEPHONE NUMBER	EMAIL ADDRESS	TELEPHONE NUMBER	EMAIL ADDRESS
SIGNATURE	DATE	SIGNATURE	DATE
HARDSHIP STATEMENT:			

Energy and Environmental Services Department

EES (8/18)

CONFLICT OF INTEREST FORM

You are being asked to complete this form because you requested Utility and/or Weatherization assistance. The State of California requires Community Action Partnership of Orange County (CAP OC) to establish safeguards to ensure its employees or its officers do not engage in actual or potential conflicts of interest. The applicable sections must be completed and returned with the Energy Intake form CSD 43 for processing. Program eligibility is solely based on income guidelines and program requirements. Your affiliation or employment with CAP OC will not be a determining factor for program eligibility.

I. Applicant Section		
First Name	Last Name	
Address	City	Zip Code
II. Affiliation Section		
Are you related or friends with an employee, board member or anyone affiliated with CAP OC?		
<input type="checkbox"/> NO <input type="checkbox"/> YES If yes, what is the first and last name of the person? _____		
III. Program Participation Section		
Has anyone in your household applied for Utility Assistance in the same program year?		
<input type="checkbox"/> NO <input type="checkbox"/> YES If yes, what is the first and last name of the person? _____		
IV. Confirmation Section		
<i>By signing this form, I affirm that I have answered all questions truthfully and to the best of my knowledge. I give Community Action Partnership permission to verify this information. I may be held liable under Federal and state law for knowingly making false or fraudulent statements.</i>		
X		

***** APPLICANT'S SIGNATURE *******TODAY'S DATE**

Office Use Only		
Certified By:		Certified Date:
Assistance Type: <input type="checkbox"/> *WX & UA <input type="checkbox"/> UA <input type="checkbox"/> *WX		Benefit Amount:
Conflict of Interest Compliance		
Application Request for Processing: <input type="checkbox"/> Approved <input type="checkbox"/> Denied		
X		
*** DEPARTMENT DIRECTOR'S SIGNATURE ***		DATE
Application Request for Processing: <input type="checkbox"/> Approved <input type="checkbox"/> Denied		
X		
*** PRESIDENT & CEO'S SIGNATURE ***		DATE
Data Entry Completed & Exported By:		Date:

Energy & Environmental Services Department (EES)
HOUSEHOLD DEMOGRAPHIC QUESTIONNAIRE COMMUNITY SERVICE BLOCK GRANT



APPLICANT (HOUSEHOLD MEMBER 1): _____

DISABLED: YES NO

DISCONNECTED YOUTH: YES NO

(Ages 14-24 neither working nor in school)

ASIAN: Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Asian

HISPANIC LATINO: Central/ South American Cuban Dominican Mexican, Chicano Other Spanish/ Latino Puerto Rican

NATIVE HAWAIIAN/ OTHER PACIFIC ISLANDER: Native Hawaiian Guamanian or Chamorro Samoan Other Pacific Islander Other Asian

LANGUAGE: English Spanish Vietnamese Korean Chinese Farsi OTHER

EDUCATION LEVEL: Grades 0-8 Grades 9-12/non-grad High school grad/ equivalency 12th grade + some post-secondary 2- or 4-years college grad Graduate or other post-secondary school State Children's Health Ins Program

HEALTH INSURANCE: Direct Purchase Employment-Based Medicaid Medicare Military Health Care Retired State Children's Health Ins Program

WORK STATUS: Employed Unemployed Unemployed (Not in Labor Force) Retired

HOUSEHOLD MEMBER 2: _____

DISABLED: YES NO

DISCONNECTED YOUTH: YES NO

(Ages 14-24 neither working nor in school)

ASIAN: Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Asian

HISPANIC LATINO: Central/ South American Cuban Dominican Mexican, Chicano Other Spanish/ Latino Puerto Rican

NATIVE HAWAIIAN/ OTHER PACIFIC ISLANDER: Native Hawaiian Guamanian or Chamorro Samoan Other Pacific Islander Other Asian

LANGUAGE: English Spanish Vietnamese Korean Chinese Farsi OTHER

EDUCATION LEVEL: Grades 0-8 Grades 9-12/non-grad High school grad/ equivalency 12th grade + some post-secondary 2- or 4-years college grad Graduate or other post-secondary school State Children's Health Ins Program

HEALTH INSURANCE: Direct Purchase Employment-Based Medicaid Medicare Military Health Care Retired State Children's Health Ins Program

WORK STATUS: Employed Unemployed Unemployed (Not in Labor Force) Retired

HOUSEHOLD MEMBER 3: _____

DISABLED: YES NO

DISCONNECTED YOUTH: YES NO

(Ages 14-24 neither working nor in school)

ASIAN: Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Asian

HISPANIC LATINO: Central/ South American Cuban Dominican Mexican, Chicano Other Spanish/ Latino Puerto Rican

NATIVE HAWAIIAN/ OTHER PACIFIC ISLANDER: Native Hawaiian Guamanian or Chamorro Samoan Other Pacific Islander Other Asian

LANGUAGE: English Spanish Vietnamese Korean Chinese Farsi OTHER

EDUCATION LEVEL: Grades 0-8 Grades 9-12/non-grad High school grad/ equivalency 12th grade + some post-secondary 2- or 4-years college grad Graduate or other post-secondary school State Children's Health Ins Program

HEALTH INSURANCE: Direct Purchase Employment-Based Medicaid Medicare Military Health Care Retired State Children's Health Ins Program

WORK STATUS: Employed Unemployed Unemployed (Not in Labor Force) Retired

ASIAN: Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Asian

HISPANIC LATINO: Central/ South American Cuban Dominican Mexican, Chicano Other Spanish/ Latino Puerto Rican

NATIVE HAWAIIAN/ OTHER PACIFIC ISLANDER: Native Hawaiian Guamanian or Chamorro Samoan Other Pacific Islander Other Asian

LANGUAGE: English Spanish Vietnamese Korean Chinese Farsi OTHER

EDUCATION LEVEL: Grades 0-8 Grades 9-12/non-grad High school grad/ equivalency 12th grade + some post-secondary 2- or 4-years college grad Graduate or other post-secondary school State Children's Health Ins Program

HEALTH INSURANCE: Direct Purchase Employment-Based Medicaid Medicare Military Health Care Retired State Children's Health Ins Program

WORK STATUS: Employed Unemployed Unemployed (Not in Labor Force) Retired

HOUSEHOLD MEMBER ():		DISABLED: YES <input type="checkbox"/> NO <input type="checkbox"/>		DISCONNECTED YOUTH: YES <input type="checkbox"/> NO <input type="checkbox"/>	
				(Ages 14-24 neither working nor in school)	
ASIAN: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Cuban <input type="checkbox"/> Dominican <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian		HISPANIC LATINO: <input type="checkbox"/> Central/ South American <input type="checkbox"/> Cuban <input type="checkbox"/> Dominican <input type="checkbox"/> Mexican, Chicano <input type="checkbox"/> Other Spanish/ Latino <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Vietnamese		NATIVE HAWAIIAN/ OTHER PACIFIC ISLANDER: <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other Asian <input type="checkbox"/> Chinese <input type="checkbox"/> Farsi <input type="checkbox"/> OTHER	
				LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Farsi <input type="checkbox"/> OTHER	
				EDUCATION LEVEL: <input type="checkbox"/> Grades 0-8 <input type="checkbox"/> Grades 9-12/non-grad <input type="checkbox"/> High school grad / equivalency <input type="checkbox"/> 12th grade + some post-secondary <input type="checkbox"/> 2- or 4-years college grad <input type="checkbox"/> Graduate or other post-secondary school <input type="checkbox"/> State Health Ins for Adults	
				WORK STATUS: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Employment-Based <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Military Health Care <input type="checkbox"/> State Children's Health Ins Program <input type="checkbox"/> Retired <input type="checkbox"/> State Health Ins for Adults	
				HEALTH INSURANCE: <input type="checkbox"/> Direct Purchase <input type="checkbox"/> Employment-Based <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Military Health Care <input type="checkbox"/> State Children's Health Ins Program <input type="checkbox"/> Retired <input type="checkbox"/> State Health Ins for Adults	
HOUSEHOLD MEMBER ():		DISABLED: YES <input type="checkbox"/> NO <input type="checkbox"/>		DISCONNECTED YOUTH: YES <input type="checkbox"/> NO <input type="checkbox"/>	
				(Ages 14-24 neither working nor in school)	
ASIAN: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Cuban <input type="checkbox"/> Dominican <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian		HISPANIC LATINO: <input type="checkbox"/> Central/ South American <input type="checkbox"/> Cuban <input type="checkbox"/> Dominican <input type="checkbox"/> Mexican, Chicano <input type="checkbox"/> Other Spanish/ Latino <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Vietnamese		NATIVE HAWAIIAN/ OTHER PACIFIC ISLANDER: <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other Asian <input type="checkbox"/> Chinese <input type="checkbox"/> Farsi <input type="checkbox"/> OTHER	
				LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Farsi <input type="checkbox"/> OTHER	
				EDUCATION LEVEL: <input type="checkbox"/> Grades 0-8 <input type="checkbox"/> Grades 9-12/non-grad <input type="checkbox"/> High school grad / equivalency <input type="checkbox"/> 12th grade + some post-secondary <input type="checkbox"/> 2- or 4-years college grad <input type="checkbox"/> Graduate or other post-secondary school <input type="checkbox"/> State Health Ins for Adults	
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HOUSEHOLD MEMBER ():		DISABLED: YES <input type="checkbox"/> NO <input type="checkbox"/>		DISCONNECTED YOUTH: YES <input type="checkbox"/> NO <input type="checkbox"/>	
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ASIAN: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Cuban <input type="checkbox"/> Dominican <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian		HISPANIC LATINO: <input type="checkbox"/> Central/ South American <input type="checkbox"/> Cuban <input type="checkbox"/> Dominican <input type="checkbox"/> Mexican, Chicano <input type="checkbox"/> Other Spanish/ Latino <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Vietnamese		NATIVE HAWAIIAN/ OTHER PACIFIC ISLANDER: <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other Asian <input type="checkbox"/> Chinese <input type="checkbox"/> Farsi <input type="checkbox"/> OTHER	
				LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Farsi <input type="checkbox"/> OTHER	
				EDUCATION LEVEL: <input type="checkbox"/> Grades 0-8 <input type="checkbox"/> Grades 9-12/non-grad <input type="checkbox"/> High school grad / equivalency <input type="checkbox"/> 12th grade + some post-secondary <input type="checkbox"/> 2- or 4-years college grad <input type="checkbox"/> Graduate or other post-secondary school <input type="checkbox"/> State Health Ins for Adults	
				WORK STATUS: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Employment-Based <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Military Health Care <input type="checkbox"/> State Children's Health Ins Program <input type="checkbox"/> Retired <input type="checkbox"/> State Health Ins for Adults	
				HEALTH INSURANCE: <input type="checkbox"/> Direct Purchase <input type="checkbox"/> Employment-Based <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Military Health Care <input type="checkbox"/> State Children's Health Ins Program <input type="checkbox"/> Retired <input type="checkbox"/> State Health Ins for Adults	