SOUTHEASTERN NORTH DAKOTA community Action®

Cass, Ransom, Richland, Sargent, Steele and Traill Counties

NORTH DAKOTA'S POVERTY FIGHTING NETWORK

Helping People. Changing Lives.

SENDCAA's Energy Share Assistance Program
What you need to apply for electric assistance?

Please fill out the following application as complete as possible*. In addition, the following information is needed to process the application:

- SFN 62 – Emergency Assistance Application, which is attached to this application.
- Your LIHEAP approval letter (If you haven't applied for LIHEAP, please visit your local human service zone office to apply)
- Proof of all household income (30 days of paystubs, child support, unemployment, TANF, SNAP, etc.)
- Photo ID of all household members 18 or older
- Copy of your Electric bill and/or disconnect

*Please note that the more information that is provided with your application will assist in the processing time of your application.

Once we receive your application, we will contact you via phone or email.

Please contact us with any questions at the 800-726-7960

Sincerely,

SENDCAA Self Sufficiency Staff

3233 South University Drive • Fargo, ND 58104-6221
Phone (701) 232-2452 • Toll free (800) 726-7960 • Fax (701) 298-3115
Website www.sendcaa.org • Email agency@sendcaa.org

EMERGENCY ASSISTANCE APPLICATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LIHEAP
SFN 62 (8-2023)

☐ Energy Share
☐ LIHEAP Emergency Assistance

*PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose a social security number will not affect participation in this program.

Are you currently on LIHEAP?
☐ Yes - What is your case Number? _____
☐ No - you MUST ALSO complete the Low Income Home Energy Assistance Program (LIHEAP) Application (SFN 529) in order for the Department to process your emergency application.

Name	Social Security Number*	Telephone Number	
Address	City	State	ZIP Code
County	List Name and Age of All Household Members		

Is your heat shut of now? ☐ Yes ☐ No

Do you have a disconnect/shut off notice for your heat ? ☐ Yes - Date of the shut off: ☐ No

Emergency assistance is needed with what fuel?
☐ Electricity ☐ Propane
☐ Fuel Oil ☐ Natural Gas
☐ Coal

Emergency assistance is needed other than fuel?
☐ Minor Home Repair ☐ Consumer Goods
☐ Minor Furnace Repair ☐ Non-Heat Electric Referral
☐ Furnace Replacement ☐ Self Reliance Referral

Name of Company That Fuel is Purchased From	Name on Account	Account Number
Dollar Amount of Emergency Assistance You Are Applying For	Dollar Amount You Paid on Energy Bills in the Last 6 Months	

List the reasons you are applying for Emergency Assistance (illness, car accident, loss of job, etc.)

Did you discuss making regular monthly or weekly payments with your energy supplier/vendor?
☐ Yes-What arrangements did you make? ☐ No-Why Not?

Have you tried to get a bank loan, family loan, or help from other agencies to pay on your bill?
☐ Yes-Assistance From? ☐ No-Why Not?

What is your plan on how to avoid needing emergency assistance in the future? Explain.

List the NET income of each household member for the application month

Name of Person #1	Income This Month	Source(s)
Name of Person #2	Income This Month	Source(s)
Name of Person #3	Income This Month	Source(s)
Name of Person #4	Income This Month	Source(s)
Total Net Income for Household		

List the Total Assets of All Members

Amount For All Household Members in Checking	Amount For All Household Members in Savings
Amount For All Household Members in Other Accounts	

Check YES by each expense and list the amount spent or anticipated to spend for **THIS APPLICATION MONTH**
Check NO, if none

Expense	Yes	No	Amount
Your out-of-pocket food costs	☐	☐	
Are you on SNAP?	☐	☐	
Rent	☐	☐	
Mortgage	☐	☐	
Property Taxes (per month)	☐	☐	
Renter/Homeowner's Insurance	☐	☐	
Water/Sewer/Garbage	☐	☐	
Electricity	☐	☐	
Heat	☐	☐	
Telephone	☐	☐	
Other Utilities	☐	☐	
Prescriptions	☐	☐	
Medical Bills	☐	☐	
Health Insurance Premiums	☐	☐	
Gas or Other Transportation Costs	☐	☐	
Vehicle Insurance (one month)	☐	☐	
Vehicle Payment (one month)	☐	☐	
Tools for Employment	☐	☐	
Clothes for Employment	☐	☐	
Other Required Employment Costs	☐	☐	
Child Care Costs	☐	☐	
Child Support Costs	☐	☐	
Spousal Support Costs	☐	☐	
Personal Care Costs	☐	☐	
Other Mandatory Expenses (explain)	☐	☐	
Does the head of household or spouse reside away from home for education or work purposes? Explain if you answered yes):	☐	☐	

ACTION PLAN

Recommended actions you can take to help avoid future emergencies.

Check if you would like more information

- Negotiate a reasonable payment plan with your energy supplier.
- Participate:
  - ☐ In Self Reliance/Budget Counseling/Case Management
  - ☐ Employment Services
- Obtain:
  - ☐ Weatherization for Your home
- Apply for Other Services:
  - ☐ Child Care Assistance Program (CCAP)
  - ☐ Health Care Coverages (HCC)
  - ☐ Supplemental Nutrition Assistance Program (SNAP)
  - ☐ Temporary Assistance for Needy Families (TANF)
  - ☐ Low Income Housing

We will help you start your Action Plan by making referrals to the above services. However, it is your responsibility to keep your appointments with them and to do whatever is necessary to make your Action Plan work for you. If you apply for Emergency Assistance again, the approval of additional payments may depend upon your efforts to succeed with your Action Plan.

By signing this application

I certify that the information I have given is correct and complete to the best of my knowledge. I understand that benefits received based on false information must be repaid and could result in a fine, imprisonment, or both.

I give my permission to Human Service Zone office to make referrals to any of the above agencies, to share information about my circumstances, and to request and receive a progress report from the above agencies.

I give my permission to LIHEAP, Health and Human Service Zone Office, Community Action, Community Options and Energy Share to verify and share information affecting my eligibility and benefits and to my energy supplier to provide information regarding my account and energy consumption.

☐ I understand that by checking this box and typing my name below, I am signing the Emergency Assistance Application. I agree that my electronic signature is the legal equivalent of my handwritten signature.

Signature	Date

Return your signed and dated emergency application and if you are not on LIHEAP, include the SFN 529 LIHEAP application to your local human service zone office
OR
Submit by mail to:
Department of Health and Human Services
Customer Support Center
PO Box 5562
Bismarck ND, 58506
OR FAX: (701)-328-1006
OR Email: **applyforhelp@nd.gov**

For questions call Customer Support Center at: 1-866-614-6005

Human service zone office locations can be found here: https://www.hhs.nd.gov/human-service/zones

Household Demographic Form

Date	First Name, M.I., Last Name		
Birthdate ____/____/_____	Age	Social Security Number _____-_____-_____	Gender ☐ Male ☐ Female | Pronouns:_____

What is your Ethnicity?	U.S Military	Are you disabled?	How many in the Household?
☐ Hispanic ☐ Non-Hispanic	☐ Active ☐ Veteran ☐ None Military	☐ Yes ☐ No	

What is your primary race?
- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Other:_____
- ☐ Multi-race (two or more of the above)
- ☐ Unknown

What is your highest level of education?
- ☐ 0-8th
- ☐ 9th-12th non-grad
- ☐ HS grad
- ☐ GED
- ☐ 12 grade + some Post-Secondary
- ☐ 2 or 4 years College Graduate
- ☐ Graduate of other Post-Secondary

What is your medical coverage?
- ☐ Medicaid
- ☐ Medicare
- ☐ ND Healthy Steps
- ☐ Military Health Care (VA)
- ☐ Direct Purchase (ACA/Marketplace)
- ☐ Employer Insurance
- ☐ None
- ☐ Other

What is your family type?
- ☐ Single Person
- ☐ Single Parent Female
- ☐ Single Parent Male
- ☐ Two Adults, No Children
- ☐ Two Parent Household
- ☐ Non-related Adults with Children
- ☐ Multigenerational Household
- ☐ Other: _____

What is your current housing situation?
- ☐ Own
- ☐ Rent
- ☐ Other Permanent housing
- ☐ Homeless
- ☐ Other
- ☐ Unknown

Work Status?
- ☐ Employed Full Time
- ☐ Employed Part Time
- ☐ Migrant Seasonal Farm Worker
- ☐ Unemployed(Short Term, 6 months or less)
- ☐ Unemployed(Long Term, more than 6 months)
- ☐ Unemployed (Not in Labor Force)
- ☐ Retired

Mailing Address	City	State ND	Zip Code	County

Primary Phone Number:	Secondary Phone Number:	Email Address:

What INCOME do you receive?	How much?	How often?	What BENEFITS do you receive?	How much?	How often?
☐ I have no income at this time			☐ Affordable Care Act Subsidy	$	
☐ Employment	$		☐ Childcare Voucher	$	
☐ Social Security	$		☐ Housing Choice Voucher (Section 8)	$	
☐ SSI	$		☐ HUD-VASH	$	
☐ SSDI	$		☐ LIHEAP	$	
☐ VA Service-Connected	$		☐ Public Housing	$	
☐ Child Support	$		☐ SNAP	$	
☐ Alimony/Spousal	$		☐ WIC	$	
☐ TANF	$		☐ Other:_____	$	
☐ Worker's Compensation	$		☐ None		
☐ Unemployment	$				
☐ Other:	$				

You certify that the information you have disclosed is correct and complete to the best of your knowledge. You understand that failure to provide the needed documentation or knowingly providing false information will result in denial of assistance and your case will be closed due to fraud. All information provided will be kept in the strictest of confidence. You agree to sign this form at your own will. Your file may be monitored by state agencies for funding and quality review purposes

Applicant Signature: _____ Date: _____

Additional Household Members

First Name MI Last Name			Relationship to Head of Household
Birthdate ____/____/_____	**Age**	**Social Security Number** _____- _____-_____	**Gender** ☐Male ☐ Female | Pronouns:_____

Are you disabled?	U.S Military	What is your Ethnicity?
☐ Yes ☐ No	☐ Active ☐ Veteran ☐ None Military	☐ Hispanic ☐ Non-Hispanic

What is your primary race?	What is your highest level of education?	What is your medical coverage?
☐ American Indian / Alaska Native	☐ 0-8th	☐ Medicaid
☐ Asian	☐ 9th-12th non-grad	☐ Medicare
☐ Black / African American	☐ HS grad/GED	☐ ND Healthy Steps
☐ Native Hawaiian / Other Pacific Islander	☐ 12 grade + some Post-Secondary	☐ Military Health Care (Dept of Defense, VA)
☐ White	☐ 2 or 4 years College Graduate	☐ Direct Purchase (Health Exchange or ACA)
☐ Other	☐ Graduate of other Post-Secondary	☐ Employment Based (through employer)
☐ Multi-race (two or more of the above)		☐ Other

What INCOME do you receive?	How much?	How often?	What BENEFITS do you receive?	How much?	How often?
	$			$	

Additional Household Members

First Name	MI	Last Name	Relationship to Head of Household
Birthdate ____/____/_____	**Age**	**Social Security Number** _____- _____-_____	**Gender** ☐Male ☐ Female | Pronouns:_____

Are you disabled?	U.S Military	What is your Ethnicity?
☐ Yes ☐ No	☐ Active ☐ Veteran ☐ None Military	☐ Hispanic ☐ Non-Hispanic

What is your primary race?	What is your highest level of education?	What is your medical coverage?
☐ American Indian / Alaska Native	☐ 0-8th	☐ Medicaid
☐ Asian	☐ 9th-12th non-grad	☐ Medicare
☐ Black / African American	☐ HS grad/GED	☐ ND Healthy Steps
☐ Native Hawaiian / Other Pacific Islander	☐ 12 grade + some Post-Secondary	☐ Military Health Care (Dept of Defense, VA)
☐ White	☐ 2 or 4 years College Graduate	☐ Direct Purchase (Health Exchange or ACA)
☐ Other	☐ Graduate of other Post-Secondary	☐ Employment Based (through employer)
☐ Multi-race (two or more of the above)		☐ Other

What INCOME do you receive?	How much?	How often?	What BENEFITS do you receive?	How much?	How often?
	$			$	

Additional Household Members

First Name	MI	Last Name	Relationship to Head of Household
Birthdate ____/____/_____	**Age**	**Social Security Number** _____- _____-_____	**Gender** ☐Male ☐ Female | Pronouns:_____

Are you disabled?	U.S Military	What is your Ethnicity?
☐ Yes ☐ No	☐ Active ☐ Veteran ☐ None Military	☐ Hispanic ☐ Non-Hispanic

What is your primary race?	What is your highest level of education?	What is your medical coverage?
☐ American Indian / Alaska Native	☐ 0-8th	☐ Medicaid
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☐ Black / African American	☐ HS grad/GED	☐ ND Healthy Steps
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☐ White	☐ 2 or 4 years College Graduate	☐ Direct Purchase (Health Exchange or ACA)
☐ Other	☐ Graduate of other Post-Secondary	☐ Employment Based (through employer)
☐ Multi-race (two or more of the above)		☐ Other

What INCOME do you receive?	How much?	How often?	What BENEFITS do you receive?	How much?	How often?
	$			$	

Please provide a brief explanation of the current situation and why you in need of emergency financial assistance.

What is your plan after assistance has been provided after assistance has ended.

Self-Sufficiency Financial Assessment

Expenses			**Income (use NET Income)**	
Expense Item	Monthly Amount	Past Due Amount	Income Source(s) all household members	Monthly Amount
Rent/Mortgage			Employment (applicant)	
Heating (fuel, oil, gas)			Employment (co- applicant)	
Electricity			Self-Employment (applicant)	
Water, Sewer, Garbage			Self-Employment (co-applicant)	
Internet/Cable			Veteran's Benefits	
Cell Phone/Telephone			Unemployment	
Groceries/Food Costs			Worker's Compensation	
Car Payment/Insurance			Short/Long-Term Disability	
Car Gas/Maintenance/Repairs			Child Support	
Bus/Uber/Lyft/Cab Fees			SSDI/SSI/Social Security	
Childcare			TANF	
Child Support			Retirement/Pension	
Legal Fees			Other	
Clothing/Uniforms/Laundry				
Other Household Items				
Loans or Debts				
Other			Other	
Total Monthly Expenses			Total Monthly Income	

Difference between Income and Expenses: _____

Release of Information
Southeastern North Dakota Community Action Agency
3233 S University Drive
Fargo, ND 58104

All household members (18 years old+) must initial and sign release of information

Last Name	First Name	MI	Date of Birth

By signing this form, I authorize the following record holder(s) to disclose the following specific confidential information about me:

Initial	Initial	Agency Name	Mutual Exchange Y or N
		Human Service Zone	
		Utility Company (*circle provider)* **Xcel Energy CCEC Ottertail Power Other** _____	
		Other	

The following information is requested: name, sex, martial status, sex/age of family member, race/ethnicity, veteran status, income verification, current housing status, services currently received and unmet needs.

The information I have requested will be used for (be specific):

Initial	Initial		Mutual Exchange Y or N
		Coordination of Services	
		Obtaining Collateral Information	
		Referrals	
		Other	

The Release of information Consent form will be in effect until _____ (not more than one year from today's date) or until termination of services.

Client Consent:

This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the agency or person. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless agreed in writing, information may be disclosed under this authorization in any form or medium including, but not limited to oral, written, or electronic transmission.

You give permission to discuss my request for assistance with the selected agencies above. It is further agreed upon that information during the application process is shared with SENDCAA employees for determining if you are eligible for services. You release SENDCAA and any of its employees from any claim arising from this authorization and disclosure.

SENDCAA employees are considered mandated reporters. SENDCAA follows the North Dakota Century Code Statute 50-25.1-03 on Child Abuse and Neglect and the North Dakota Century Code Statute 50-25.2-03 on Vulnerable Adult Protection.

Applicant Printed Name	Applicant Signature	Date
Co-applicant Printed Name	Co-Applicant Signature	Date
Agency Staff Printed Name	Agency Staff Signature	Date

I understand that Energy Share can only assist with the last 90 days of usage for the electric portion of my bill if I have a heat source of Natural Gas, Propane, Fuel or Wood and have a LIHEAP Approval. If the amount owing exceeds the amount of assistance. I _____ understand I will be responsible for the remainder of the bill. If this amount is not paid, could result in a disconnection and/or impact future requests of assistance in the Energy Share program.

By signing below, I acknowledge the above statement as written.

Signature of participant_____ Date _____

Are you **interested** in meeting with a case manager monthly to help you work on accessing resources and support in your household?

Yes _____ No _____

Phone number _____