



APPOINTMENT DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

Please arrive to your appointment on time, late arrivals may not be accommodated, and you will need to reschedule.

**YOU MUST BRING THE FOLLOWING DOCUMENTS:**

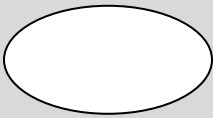
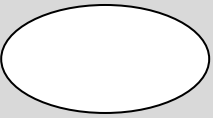
- CURRENT PHOTO ID (REAL ID):** UNITED STATES ID or DRIVER'S LICENSE FOR ALL THE ADULTS LIVING IN THE HOUSEHOLD (18 YEARS OF AGE AND OLDER). IF ID'S STATES **FEDERAL LIMITS APPLY** PLEASE ALSO BRING US BIRTH CERTIFICATE, US PASSPORT, NATURLIZATION CERTIFICATE N-550 OR N-570, PERMANENT RESIDENCY, AMERICAN INDIAN CARD WITH A CLASSIFICATION CODE KIC OR DOCUMENT OF DIRECT RECEIPT OF SSI OR SSA BENEFITS.
- ALL PAGES OF CURRENT ENERGY BILLS:** (PG&E, TID, MID, PROPANE, WOOD, ETC.) MUST SHOW ACCOUNT NUMBER, NAME, PHYSICAL ADDRESS, MAILING ADDRESS, BILLING DATE & DUE DATE, TOTAL CURRENT CHARGES & ANY PREVIOUS BALANCE. LATE NOTICES (48 HOUR NOTICES) WILL NOT BE ACCEPTED. PLEASE BRING ALL YOUR ENERGY BILLS.
- SOCIAL SECURITY CARDS:** FOR EVERYONE LIVING IN THE HOUSEHOLD. (MEDI-CAL CARDS, SHOT RECORDS AND BIRTH CERTIFICATE WILL BE ACCEPTED FOR CHILDREN ONLY.)
- VERIFICATION OF CALFRESH/CALWORKS BENEFITS for CURRENT MONTH:**
- Declaration statement will be necessary attesting to additional income at your appointment, from everyone in Household who has obtained income within the last 4 weeks such as Wages, Social Security, Child Support, Unemployment, Disability, Alimony, Pension, and or any Cash Gifts or Borrowed Money.  
**\*\*If Verification of Benefits is NOT provided, ALL income within last 4 weeks for must be provided\*\***

**ALL DOCUMENTS MUST BE PRINTED AND READY TO PROVIDE AT YOUR APPOINTMENT  
ORIGINAL DOCUMENTS ARE ACCEPTABLE AND COPIES WILL BE MADE FOR APPLICATION**

**State of California**  
**Department of Community Services and Development**  
 Energy Intake Form  
 CSD 43 (07/2024)

<i>Official Use Only:</i>	
Priority Points	
A.C.C.	
Eligibility Cert Date	

Agency:	Intake Initials:	Intake 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:			

<b>PEOPLE LIVING IN HOUSEHOLD</b> Enter the total number of people living in the household, including yourself → 	<b>INCOME</b> 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 <b>gross</b> monthly income for <b>all</b> 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	<b>Total Monthly Income</b> \$

**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
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other <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? <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		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 <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
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other <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
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other <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
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other <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 <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
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <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 <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
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <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.

<b>X</b>		
	<b>*** APPLICANT'S SIGNATURE ***</b>	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.

<b>APPLICANT: DO NOT FILL OUT THE INFORMATION BELOW. THIS SECTION IS FOR OFFICIAL USE ONLY.</b>	
Utility Assistance being provided under which program → <input type="checkbox"/> HEAP <input type="checkbox"/> Fast Track <input type="checkbox"/> HEAP WPO <input type="checkbox"/> ECIP WPO	
Base Benefit \$ _____	Supplement \$ _____ Total Benefit \$ _____
Total Energy Cost \$ _____	Energy Burden _____
Energy Services Restored after disconnection: <input type="checkbox"/> Yes <input type="checkbox"/> No	Disconnection of Energy Services prevented: <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Referred for WX: <input type="checkbox"/>	Home Already Weatherized: <input type="checkbox"/>



**Merced County Community Action Agency  
Energy/Weatherization Department  
1235 W. Main St. – P.O. Box 2085 – Merced, CA**

**LIHEAP APPLICANT FINANCIAL MANAGEMENT COUNSELING**

**Benefit Program:** \_\_\_\_\_

Participant: \_\_\_\_\_  
(Last) (First) (Street) (City/Town/Zip) (Phone#)

**1. Monthly Household Income**

- a. Source(s) of Income: \_\_\_\_\_
- b. Gross Monthly Income: \_\_\_\_\_
- c. Net Monthly Income: \_\_\_\_\_  
(After deductions)

**2. Monthly Financial Obligations**  
(Monthly bills paid by applicant)

- a. Rent/Mortgage payment: \_\_\_\_\_
- b. Food Exp (out of pocket): \_\_\_\_\_
- c. Household Exp (Toiletries): \_\_\_\_\_
- d. Credit Card Payment: \_\_\_\_\_
- e. TV/Cable Payment: \_\_\_\_\_
- f. Telephone Payment: \_\_\_\_\_
- g. Water/Garbage Payment: \_\_\_\_\_

- h. Utility Payment: \_\_\_\_\_  
(PG&E, MID, TID, PROPANE)
- i. Transportation Exp: \_\_\_\_\_
- j. Car Payment: \_\_\_\_\_
- k. Other monthly payments: \_\_\_\_\_  
(Be specific)

GRAND TOTAL \_\_\_\_\_

Participants in MCCAA's direct assistance programs are required to present documented proof of monthly income

- 3. Possible available cash after all monthly obligations are paid \_\_\_\_\_

**4. Problems:**

(Why does applicant need financial assistance from MCCAA?)

- 5. Recommendation: MCCAA will assist in paying part or all of the applicant's utility obligations  
(Specify what Utility is to be paid)

Utility Company Name: \_\_\_\_\_

MCCAA to Pay: \_\_\_\_\_

Applicant required to pay or make arrangements with Utility Company on remaining account balance

A representative of the Merced County Community Action Agency provided me with Financial Management Counseling. During counseling, I was informed that in order for me to receive assistance with my \_\_\_\_\_, I must pay \$\_\_\_\_\_ or make arrangements with my Utility Company for that amount. I understand that I must pay my share before the MCCAA will pay on my behalf.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Intake Worker's Signature

\_\_\_\_\_  
Date

Client Tracker Form

Have you received assistance from any of the programs listed below in the last 30 days?

<input type="checkbox"/> Heap/Fast Track <input type="checkbox"/> WX <input type="checkbox"/> Community Services	<input type="checkbox"/> WIC <input type="checkbox"/> Parent Involve <input type="checkbox"/> Counseling <input type="checkbox"/> REACH	<input type="checkbox"/> Rent Assist. <input type="checkbox"/> Shelter <input type="checkbox"/> Housing	<input type="checkbox"/> Referral Out <input type="checkbox"/> Social Services <input type="checkbox"/> Health Services <input type="checkbox"/> Mental Health	<b>Family Type:</b> <input type="checkbox"/> Single Parent F <input type="checkbox"/> Single Parent M <input type="checkbox"/> Two Parents <input type="checkbox"/> Individual <input type="checkbox"/> Couple <input type="checkbox"/> Other
<input type="checkbox"/> Head Start <input type="checkbox"/> Child Development <input type="checkbox"/> State Pre-School <input type="checkbox"/> Child Care	<input type="checkbox"/> Disabilities <input type="checkbox"/> Transportation <input type="checkbox"/> CPR/First Aid	<input type="checkbox"/> Food Pantry <input type="checkbox"/> Clothing <input type="checkbox"/> Senior Nutrition	<input type="checkbox"/> Other:	

**Household Member 1      Household Member 2      Household Member 3      Household Member 4**

SS#				
Last Name				
First Name				
DOB / Age				
Disabled				
Education				
Health Insurance				
Veteran				

**Household Member 5      Household Member 6      Household Member 7      Household Member 8**

SS#				
Last Name				
First Name				
DOB / Age				
Disabled				
Education				
Health Insurance				
Veteran				

**\*I certify that this statement is true and correct to the best of my knowledge, and authorize the release of all information necessary for verification purposes.**

**\*Yo certifico que esta delaracion es cierta y correcta, y autorizo el uso de esta informacion para proposito de verificacion.**

**\*Kuv lees paub tias nqe lus no muaj tseeb thiab raug rau qhov zoo tshaj plaws ntawm kuv txoj kev paub, thiab tso cai tso tawm ib qho thiab tag nrho cov ntaub ntawv tsim nyog rau kev ua pov thawj.**

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date



**Household Member 9**

**Household Member 10**

**Household Member 11**

**Household Member 12**

SS#				
Last Name				
First Name				
DOB / Age				
Disabled				
Education				
Health Insurance				
Veteran				

# 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 CA	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