RESET

ជតិ្យាគស់ាគ៌ាអំពីជំនួយលើដ្ឋ ឬ្ឋនឹងដ្ឋក្រុស (ENERGY ASSISTANCE PROGRAM) ។ | 关于能源补助计划的重要消息 | Важные сведения о программе помощи при оплате счетов за энергию | Información importante sobre un programa de asistencia para el pago de energía | Thông báo quan trọng về chương trình trợ giúp năng lượng

APPLICATION FOR THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

To apply for Energy Assistance, you must complete all questions front and back and sign at the red "X". Be sure your correct and complete name and address is entered below. If incorrect, cross out and PRINT correctly in space provided below. **YOU CAN ALSO APPLY ONLINE AT WWW.COMPASS.STATE.PA.US.**

YOUR NAME AND ADDRESS

Your county assistance office address

DHS USE ONLY

☐ CRISIS ☐ CASH

Application Registration Number

County

District

Record Number

Worker I.D.

☐ Rejected ☐ Approved

Date

If you do not understand these instructions, contact your local county assistance office.

1 Please complete this section for the head of household.
*Use the codes from page 2 to help provide the details.

Name (Include Last, First Middle Initial)	Date of Birth	Sex	Social Security Number

Home Address (Include Street, Apt. Number, City, State & ZIP Code+4)

Mailing Address if different (Include Street, Apt. Number, City, State & ZIP Code+4)

County You Live In	Phone Number: ( )	Citizenship*	Race (Optional)*	Ethnicity (Optional)*	Marital Status*

If you are currently receiving Cash, Medical Assistance, or SNAP benefits, may we use the income you have on file? ☐ Yes ☐ No

2 Do you read, write and understand English? ☐ Yes ☐ No If no, what language? _____

3 Are You:

☐ Renting with heat included
☐ Renting with heat **not** included
☐ An unrelated roomer
☐ Renting subsidized housing/Section 8 housing with heat included
☐ Renting subsidized housing/Section 8 housing with heat **not** included
☐ An owner or are you buying your home
☐ Other: _____

If heat is included in your rent, attach a note from your landlord stating that heat is included and what type of heat is used.

4 What is your main heating source? Choose the type of energy that heats your home or is being used if your main heating source is not working. Attach a copy of your last bill or a statement from a utility or fuel dealer stating the type of fuel and that you are accepted as a customer.

☐ Electric ☐ Fuel Oil ☐ Coal ☐ Natural Gas ☐ Kerosene ☐ Propane or Bottled Gas ☐ Blended Fuel ☐ Wood/Other

4a Do you need electricity to run your main heating source (secondary heat)? ☐ Yes ☐ No

5 Check if any of the following apply and provide explanation if needed:

☐ Electricity is shut off
☐ Gas is shut off
☐ Ran out of fuel
☐ Have a shut-off notice for electricity
☐ Have a shut-off notice for gas
☐ Will run out of fuel within 15 days
☐ Main heating source is not working

Explain: _____

LIHEAP Low-Income Home Energy Assistance Program

COMPASS CLICK. APPLY. BENEFIT.

6 **Which utility company or fuel dealer do you want to receive your LIHEAP grant?** Write their name and address, and your account information.

Name of Utility Company or Fuel Dealer	Account Number
Address (Include Street, City, State & ZIP Code+4)	Name on Account

7 Please list your electric company if not listed above

Name of Electric Company	Account Number

8 Do you use any other heating source in your home? ☐ Yes ☐ No

If **yes**, please explain: _____

9 If you are in subsidized/public housing, do you receive a utility allowance check? ☐ Yes ☐ No

If **yes**, how much? $ _____

10 Does anyone in your household receive financial assistance for a disability? ☐ Yes ☐ No

If **yes**, who? _____

11 List the people who live with you at this address. Include all children and adults. Include related roomers. Include all unrelated roomers who share household expenses. Do not include anyone in jail/prison. Do not include the household member listed in block 1. **See "Did you remember to..." on page 4.**

Use the codes below to help provide the details for each individual in your household.

CITIZENSHIP*: (1) U.S. Citizen, (2) Permanent Alien, (3) Temporary Alien, (4) Refugee, (5) Other-not eligible for benefits (All non-U.S. citizens must provide proof of citizenship status.)

RACE*: (optional) (1) Black or African American, (3) American Indian or Alaskan Native:, (4) Asian, (5) White, (7) Native Hawaiian or other Pacific Islander. List all groups that apply.

ETHNICITY*: (optional) (1) Non-Hispanic, (2) Hispanic or Latino

MARITAL STATUS*: (1) Single, (2) Married, (3) Common Law Marriage, (4) Separated, (5) Divorced, (6) Widow/Widower

Name (Include Last, First, Middle Initial)	**Birthdate** (MM/DD/YY)	**Sex** M/F	**Social Security Number**	**Citizenship***	**Race*** (Optional)	**Ethnicity*** (Optional)	**Marital Status ***	**Relationship to You**
Person 1								
If this person is currently receiving Cash, Medical Assistance, or SNAP benefits, may we use the income we have on file for this person? ☐ Yes ☐ No								
Person 2								
If this person is currently receiving Cash, Medical Assistance, or SNAP benefits, may we use the income we have on file for this person? ☐ Yes ☐ No								
Person 3								
If this person is currently receiving Cash, Medical Assistance, or SNAP benefits, may we use the income we have on file for this person? ☐ Yes ☐ No								
Person 4								
If this person is currently receiving Cash, Medical Assistance, or SNAP benefits, may we use the income we have on file for this person? ☐ Yes ☐ No								

If you have additional people in your house, please provide their information on a separate piece of paper and send it along with this application.

Apply online at www.compass.state.pa.us

Using income on file for someone? You don't need to list them or their income in question 12.

12 **Tell us about income for the people in your household.** Please tell us about all income, before taxes and deductions. **Types/ sources of income include money from:** Employment, Veteran's Benefits, Unemployment Compensation, Black Lung benefits, Social Security, Support, Workers Compensation, Interest/Dividends, Rental Income. **See "Did you remember to..." on page 4.**

Name of person with income	Type/source of income	Start Date	Date of First Paycheck	How much each month?
Name of person with income	Type/source of income	Start Date	Date of First Paycheck	How much each month?
Name of person with income	Type/source of income	Start Date	Date of First Paycheck	How much each month?
Name of person with income	Type/source of income	Start Date	Date of First Paycheck	How much each month?

13 Are you interested in free weatherization service? Weatherization services include home insulation and heating system evaluation. ☐ Yes ☐ No

14 Are you or anyone in your household fleeing to avoid prosecution or custody for a crime, or an attempt to commit a crime that would be classified as a felony? ☐ Yes ☐ No

If **yes**, who? _____

15 Is anyone in the U.S. Military or has anyone been in the U.S. Military? ☐ Yes ☐ No

If **yes**, who? _____

Is anyone a widow, spouse or child (under age 18) of anyone in the U.S. Military or anyone who has been in the U.S. Military? ☐ Yes ☐ No

If **yes**, who? _____

Certification

1. My signature on this application gives my permission to the Department of Human Services or its authorized agent to: (a) check any information I give about where I live, my jobs, income, resources, energy supply and energy supplier; (b) share information with my energy supplier and receive information from my energy supplier to allow DHS to obtain a record of my annual energy consumption, cost and billing information for purposes of program evaluation, operation, or reporting; and (c) complete any survey in connection with energy assistance.
2. If you fail to provide a Social Security number or fail to complete the Energy Assistance Affidavit below, you are ineligible for benefits.

Energy Assistance Affidavit

I certify that: (check all that apply)

☐ I provided Social Security numbers for all household members.

☐ To the best of my knowledge, these household members do not have Social Security numbers:

_____ Print Name _____ Print Name

_____ Print Name _____ Print Name

☐ The following household members are exercising their rights under Section 7 of the Privacy Act of 1974, and refuse to disclose their Social Security Number or may be unable to because they are a victim of domestic violence:

_____ Print Name _____ Print Name

_____ Print Name _____ Print Name

3. I authorize the release of LIHEAP eligibility information to and from my energy suppliers or weatherization agencies and allow them to seek assistance for which I may be eligible. The assistance may include LIHEAP Cash, Crisis, or Weatherization benefits.
4. I understand I have the right to appeal any decision or undue delay in decision which I consider improper regarding this application.
5. I affirm that Pennsylvania is my legal residence.
6. I understand any Social Security number(s) given will be used in the administration of this program, including cross matches with other programs.
7. I understand that I will be sent a notice of eligibility or ineligibility and, if eligible, the notice will state the amount of my benefit.
8. I further understand that if my household is eligible for a LIHEAP cash benefit, it must be sent directly to my utility company or fuel dealer unless I am a renter and my heat is included in my rent or my fuel is supplied by a fuel dealer who does not accept vendor payment.
9. I certify that, subject to penalties provided by law, the information I gave is true, correct and complete to the best of my knowledge.
10. I know that if I give false information, I can be penalized by fine and/or imprisonment.
11. I understand by signing this application, I may not qualify because LIHEAP money has run out.
12. If your household is eligible for LIHEAP, you may receive a Fast Track consent form in the mail that could allow you and your household members to be automatically enrolled in Medical Assistance.

Please Sign Here - Use Ink

X _____ Signature _____ Date

Apply online at www.compass.state.pa.us

Did you remember to...

- ☐ Fill out all required information clearly and completely.
- ☐ Provide Social Security numbers for **all** household members or complete the Energy Assistance Affidavit in the Certification section on page 3.
- ☐ Send proof of immigration status if you are a non-U.S. citizen.
- ☐ If you rent with heat included, send a copy of your lease or a signed, written statement from your landlord explaining how you pay for heat and the type of heat used.
- ☐ If you pay for heat, send a bill for your main heating source. Attach a copy of your utility bill dated within 2 months of the date you submit your application. For other fuels provide a bill/ receipt of a purchase from January of the previous heating season to present.
- ☐ If you would like payment sent to your secondary heating provider, enclose a copy of your main **AND** secondary heating bills.
- ☐ Send proof of all household income.

  Example: If you apply in November and are sending:

  a) one month of income – send proof for October, the month prior to application.

  b) 12 months of income – send proof for November of the previous year through October of the current year.

  PROOF INCLUDES PAY STUBS, AWARD LETTERS, EMPLOYER STATEMENTS, ETC.
- ☐ If you told us you have no income or if your income is less than the cost of your monthly basic living needs, send a statement explaining how your household pays for basic living needs (food, rent, etc.).
- ☐ Sign and date your application.
- ☐ Mail your completed application and all documents to your local county assistance office. If you are not sure where that is, call 1-866-857-7095.

IF YOU DO NOT SEND THE PROOF WE NEED WITH THIS FORM, WE WILL NOT BE ABLE TO PROCESS YOUR APPLICATION.

Voter Registration (Optional)

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

To register, you must: 1) Be at least 18 on the day of the next election; 2) Be a citizen of the United States for at least one month PRIOR TO THE NEXT ELECTION; 3) Reside in Pennsylvania and the voting district at least 30 days prior to the next election.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Please contact the county assistance office if you would like help. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of the Commonwealth, PA Department of State, Harrisburg, PA 17120. (Toll-free telephone number 1-877-VOTESPA.)

COUNTY ASSISTANCE OFFICE STAFF WILL COMPLETE THIS BOX BASED UPON YOUR RESPONSE ABOVE

☐ Given to Client __/__/__	☐ Sent to voter registration __/__/__	☐ Mailed to Client __/__/__
☐ Declined, not interested __/__/__	☐ Not a U.S. citizen __/__/__	☐ Declined, already registered __/__/__

If you have a disability and need this application in large print or another format, please call our **Helpline** at **1-800-692-7462.**
TDD Services are available by calling PA Relay at **711.**

COMPASS
CLICK. APPLY. BENEFIT.

Apply online at www.compass.state.pa.us

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice contains important information about the privacy of your medical information. If you need this notice in another language or someone to interpret, please contact your local county assistance office. Language assistance will be provided free of charge.

Este aviso contiene información importante acerca de la privacidad de su información médica. Si necesita este aviso en otro idioma o alguien para que interprete, comuníquese con la Oficina de Asistencia de su Condado. La asistencia bilingüe será gratuita.

Данное уведомление содержит важные сведения относительно конфиденциальности вашей медицинской информации. Если вам нужно данное уведомление на другом языке или вам нужны услуги устного переводчика, обращайтесь в Бюро помощи вашего округа (County Assistance Office). Переводческие услуги предоставляются бесплатно.

此通知包括关于您的医疗信息的个人隐私方面的重要资料。如果您需要此通知译成其它语言或需要有人替您翻译，请联系您所在地区的郡县援助办事处。可提供免费语言协助。

Thông báo này gồm những thông tin quan trọng về việc bảo mật các chi tiết y tế cá nhân của quí vị. Nếu cần có thông báo này bằng một ngôn ngữ khác hay người để thông dịch, xin quí vị liên lạc với Văn Phòng Trợ Cấp Địa Phương. Trợ giúp ngôn ngữ sẽ được cung cấp miễn phí.

សំបុត្រនេះមានពត៌មានសំខាន់អំពីការរក្សាទុកជាសម្ងាត់នូវពត៌មានពេទ្យ របស់អ្នកអ្នក។ បើអ្នកអ្នកត្រូវការសំបុត្រនេះ ជាភាសាផ្សេងទៀត ឬត្រូវការអ្នកណាម្នាក់ដើម្បីបកប្រែ សូមទាក់ទងការិយាល័យជំរឿនប្រៀរបស់អ្នកអ្នក។ ជំនួយខាងភាសានឹងផ្តល់អោយដោយឥតគិតថ្លៃ។

يحتوي هذا الإخطار على معلومات هامة حول خصوصية المعلومات الطبية المتعلقة بك. إذا كنت بحاجة إلى هذا الإخطار بلغة أخرى أو إلى شخص ما لترجمته لك، فيرجى الاتصال بمكتب معونة المقاطعة المحلي. وستقدم المساعدة اللغوية مجانًا.

The Department of Human Services (DHS) provides and pays for many types of benefits and social services. We also determine an individual's eligibility to receive benefits and services. To do these things, we have to collect personal and health information about you and/or your family. The information we collect about you and/or your family is private. We call this information "protected health information."

DHS does not use or disclose DHS health information unless it is permitted or required by law. DHS is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices concerning protected health information and to notify affected individuals in the case of a breach of unsecured protected health information. As a "covered entity," DHS must follow applicable laws protecting the privacy of your protected health information which include the Health Insurance Portability and Accountability Act (HIPAA) privacy rules. Under HIPAA, Medicaid agencies, certain health plans and health care providers are examples of covered entities that must comply with HIPAA. Other laws that may apply include rules concerning confidential information about Medical Assistance, other benefits, behavioral health, substance abuse/ treatment and HIV/AIDS. When we use or disclose protected health information, we make every reasonable effort to limit its use or disclosure to the minimum necessary to accomplish the intended purpose. This notice explains your right to privacy of your protected health information and how we may use and disclose that information. For more information on DHS privacy practices, or to receive another copy of this notice, please contact us. For information on how to contact us, see the "Questions or Complaints" section on the last page of this notice.

We are required by law to follow the terms of this notice. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information we maintain. If we make an important change in our privacy policies or procedures, we will post a revised copy of the notice on our website and/or provide you with a new privacy notice by mail or in person. You may request and receive a paper copy of this notice at any time.

What is protected health information?

Protected health information is information about you that relates to a past, present or future physical or mental health condition, treatment or payment for treatment, and that can be used to identify you. This information includes any information, whether verbal or recorded in any form, that is created or received by DHS or persons or organizations that contract with DHS. This includes electronic information and information in any other form or medium that could identify you, for example:

- Your name (or names of your children)
- Address
- Date of birth
- Admission/discharge date
- Diagnostic code
- Telephone number
- DHS case number
- Social Security number
- Medical procedure code

Who sees and shares my health information?

DHS professionals (such as caseworkers and other county assistance office and program staff) and people outside of DHS (such as our contractors, health maintenance organization (HMO) staff, nurses, doctors, therapists, social workers and administrators) may see and use your health information to determine your eligibility for benefits, treatment, payment or for other required or permitted reasons. Sharing your health information may relate to services and benefits you had before, receive now, or may receive later. DHS will not use or share genetic information about you when deciding if you are eligible for Medicaid.

Why is my protected health information used and disclosed by DHS?

There are different reasons why we may use or disclose your protected health information. The law says that we may use or disclose information without your consent or authorization for the reasons described below.

For Treatment: We may use or disclose information so that you can receive medical treatment or services. For example, we may disclose information your doctor, hospital or therapist needs to know to give you quality care and to coordinate your treatment with others helping with your care.

For Payment: We may use or disclose information to pay for your treatment and other services. For example, we may exchange information about you with your doctor, hospital, nursing home, or another government agency to pay the bills for your treatment and services.

For Operating Our Programs: We may use or disclose information in the course of our ordinary business as we manage our various programs. For example, we may use your health information to contact you to provide information about appointments, health-related information and benefits and services. We may also review information we receive from your doctor, hospital, nursing home and other health care providers to review how our programs are working or to review the need for and quality of health care services provided to you and/or your family.

For Public Health Activities: We report public health information to other government agencies concerning such things as contagious diseases, immunization information, and the tracking of some diseases such as cancer.

For Law Enforcement Purposes and As Required by Legal Proceedings: We will disclose information to the police or other law enforcement authorities as required by court order.

For Government Programs: We may disclose information to a provider, government agency or other organization that needs to know if you are enrolled in one of our programs or receiving benefits under other programs such as the Workers' Compensation Program.

For National Security: We may disclose information requested by the federal government when they are investigating something important to protect our country.

For Public Health and Safety: We may disclose information to prevent serious threats to health or safety of a person or the public.

For Research: We may disclose information for permitted research purposes and to develop reports. These reports do not identify specific people.

For Coroners, Funeral Directors and Organ Donation: We may disclose information to a coroner or medical examiner for identification purposes, cause of death determinations, organ donation and related reasons. We may also disclose information to funeral directors to carry out funeral-related duties.

For Reasons Otherwise Required By Law: DHS may use or disclose your protected health information to the extent that the use or disclosure is otherwise required by law. The use or disclosure is made in compliance with the law and is limited to the requirements of the law.

Do other laws also protect certain health information about me?

DHS also follows other federal and state laws that provide additional privacy protections for the use and disclosure of information about you. For example, if we have HIV or substance abuse information, with a few exceptions, we may not release it without special, signed written permission that complies with the law. In some situations, the law also requires us to obtain written permission before we use or release information concerning mental health or intellectual disabilities and certain other information.

Can I ask DHS to use or disclose my health information?

Sometimes, you may need or want to have your protected health information sent or otherwise disclosed to someone or somewhere for reasons other than treatment, payment, operating our programs, or other permitted or required purpose not needing your written authorization. If so, you may be asked to sign an authorization form, allowing us to send or otherwise disclose your protected health care information as you request.

The authorization form tells us what, where and to whom the information will be sent or otherwise disclosed. You may revoke your authorization or limit the amount of information to be disclosed at any time by letting us know in writing, except to the extent that DHS has already taken action in reliance upon the authorization.

If you are younger than 18 years old and, by law, you are able to consent for your own health care, then you will have control of that health information. You may ask to have your health information sent to any person who is helping you with your health care.

Except as described in this Notice, we will not use or disclose your health information without your written authorization. For example, HIPAA generally requires written authorization before a covered entity may use or disclose an individual's psychotherapy notes. In most cases, HIPAA also requires written authorization before a covered entity may use or disclose protected health information for marketing purposes or before it sells it.

What are my rights regarding my health information?

As a DHS client, you have the following rights regarding your protected health information that we use and disclose:

Right to See and Copy Your Health Information: You have the right to see most of your protected health information and to receive a copy of it. If you want copies of information you have a right to see, you may be charged a small fee. However, generally, you may not see or receive a copy of: (1) psychotherapy notes; or (2) information that may not be released to you under federal law.

If we deny your request for protected health information, we will provide you a written explanation for the denial and your rights regarding the denial.

DHS does not receive or keep a file of all of your protected health information. Doctors, hospitals, nursing homes and other health care providers (including an HMO, if you are enrolled in one) may also have your protected health information. You also have a right to your health information through your doctor or other provider who has these records.

Right to Correct or Add Information: If you think some of the protected health information we have is wrong, you may ask us in writing to correct or add new information. You may ask us to send the corrected or new information to others who have received your health information from us. In certain cases, we may deny your request to correct or add information. If we deny your request, we will provide you a written explanation of why we denied your request. We will also explain what you can do if you disagree with our decision.

Right to Receive a List of Disclosures: You have the right to receive a list of where your protected health information has been sent, unless it was sent for purposes relating to treatment, payment, operating our programs, or if the law says we are not required to add the disclosure to the list. For example, the law does not require us to add to the list any disclosures we may have made to you, to family or persons involved in your care, to others you have authorized us to disclose to, or for information disclosed before April 14, 2003.

Right to Request Restrictions on Use and Disclosure: You have the right to ask us to restrict the use and disclosure of your protected health information. We may not be able to agree to your request. In fact, in some situations, we are not permitted to restrict the use or disclosure of the information. If we cannot comply with your request, we will tell you why. Except as otherwise required by law, we must grant your request to restrict disclosure to a health plan if the purpose of disclosure is not for treatment and the medical services to which the request applies have been paid out-of-pocket in full.

Right to Request Confidential Communication: You may ask us to communicate with you in a certain way or at a certain location. For example, you may ask us to contact you only by mail.

Right to Receive Notification of a Breach: You have the right to receive notification if there is a breach of your unsecured protected health information

Whom do I contact about my rights or to ask questions about this notice?

You can contact the DHS HIPAA helpline, toll-free at 800-692-7462 to discuss your rights or to ask questions about this notice. You can also contact your caseworker or health care provider or write to DHS's Privacy Office, 3rd Floor West, Health and Welfare Building, 7th and Forster Streets, Harrisburg, PA 17120.

You can receive important information or updates to this notice by visiting DHS's Web site at **www.dhs.pa.gov**.

How do I file a complaint?

You may contact either office listed below if you want to file a complaint about how DHS has used or disclosed information about you. There is no penalty for filing a complaint. Your benefits will not be affected or changed if you file a complaint. DHS and its employees and contractors cannot and will not retaliate against you for filing a complaint.

PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES PRIVACY OFFICE
3RD FLOOR WEST, HEALTH AND WELFARE BUILDING
7TH AND FORSTER STREETS
HARRISBURG, PA 17120

REGION III
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS
150 S. INDEPENDENCE MALL WEST - SUITE 372
PHILADELPHIA, PA 19106-9111

Effective: April, 2003 – Revised July 28, 2015

pennsylvania
DEPARTMENT OF HUMAN SERVICES