

APPLICATION FOR STATE EMERGENCY RELIEF

Michigan Department of Health and Human Services

Case Name:
Case Number:
Date:
MDHHS Office:
Specialist / ID: /
Phone:
Fax:
Individual ID:

I hereby make application for the State Emergency Relief (SER) Program. I understand that the following information will be used in the determination of my eligibility for SER. I also understand that there may be a delay in processing if there is missing information. If this application is for burial services, I understand that it must be received by the MDHHS office in my area no later than 10 business days after the burial, cremation or donation takes place. **For energy related emergencies, the SER crisis season runs from November 1 through May 31. Requests for those services will be denied June 1 through October 31.**

HOUSEHOLD INFORMATION – Attach extra pages if you need to include additional members

List **everyone** who lives in your home, including adults and children temporarily absent due to illness or employment. People are considered members of your household if they sleep and keep their belongings in your home. Be sure to include the date of birth and citizenship status for each member. If you are applying for **burial assistance only**, list the deceased first.

Name	Relationship to you	Social Security number	Date of birth	Citizen?
	SELF			<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

HOUSEHOLD ADDRESS

Address (Number and street name, Apt., etc.)	City	State	Zip code
--	------	-------	----------

MAILING ADDRESS, if different than above

Address (Number and Street Name, Apt., etc.)	City	State	Zip code
--	------	-------	----------

CONTACT INFORMATION

Phone number to reach you	Contact name and number to leave messages	Email address
---------------------------	---	---------------

Has anyone ever been convicted of a drug-related felony that occurred after August 22, 1996? Yes No
 ▶ If yes, who? _____ Convicted more than once? Yes No

Is anyone in violation of probation or on parole? Yes No
 ▶ If yes, who? _____

HOW DO YOU HEAT YOUR HOME? Natural Gas Propane Wood No heat obligation
 Fuel oil Electricity Coal Unknown

Has your electricity been turned off? No Yes, date service was turned off: _____

Have you received a past due or shut off notice for your electricity?
 No Yes, when is electric service scheduled to be turned off: _____

Has your heat been turned off or have you run out of your only heating fuel source?
 No Yes, date heat was turned off or when fuel ran out: _____

Have you received a past due or shut off notice for your heat or are you at risk of running out of your household heating fuel?
 No Yes, number of days until fuel runs out or date service is scheduled to be shut off: _____

HOME HEATING CREDIT - Did you receive the Home Heating Credit in the last 6 months? No Yes, month received _____

HAVE YOU OR DO YOU CURRENTLY RECEIVE OTHER BENEFITS FROM MDHHS? Yes No

HAVE YOU RECEIVED ENERGY ASSISTANCE (Example: MEAP) FROM ANOTHER AGENCY OR THROUGH A PROVIDER-SPONSORED PROGRAM SINCE OCTOBER 1st? Yes No
 If yes, from which agencies/provider(s)? _____

EMERGENCY NEED - Check the service(s) you are requesting and the amount needed to resolve the emergency - ATTACH PROOF

**Payment for deliverable fuel will not be made if, at the time of delivery, it is confirmed you have more than 25 percent of fuel remaining in your tank.*

- | | |
|---|--|
| <input type="checkbox"/> Eviction/relocation \$ _____
<input type="checkbox"/> Security Deposit \$ _____
<input type="checkbox"/> Moving Expenses \$ _____
<input type="checkbox"/> Mortgage \$ _____
<input type="checkbox"/> Homeowner's Insurance \$ _____
<input type="checkbox"/> Property Taxes \$ _____
<input type="checkbox"/> Furnace Repair \$ _____
<input type="checkbox"/> Home Repairs \$ _____
Type of repair needed? _____ | <input type="checkbox"/> Heat \$ _____
*If deliverable fuel, % remaining in tank _____
If this is a prepaid account, amount in account \$ _____
<input type="checkbox"/> Electricity \$ _____
If this is a prepaid account, amount in account \$ _____
<input type="checkbox"/> Water/Sewer \$ _____
<input type="checkbox"/> Cooking Gas \$ _____
<input type="checkbox"/> Burial/cremation services \$ _____
<input type="checkbox"/> Migrant hospitalization \$ _____ |
|---|--|

Case Name	Case Number	Specialist
-----------	-------------	------------

HOUSEHOLD VEHICLE(S) - Does your household have any vehicles? No Yes → ATTACH PROOF OF CURRENT VALUE

- Car Truck Boat Camper/trailer Motorcycle RV Other vehicle

Name(s) on Title or Registration	Make and Model	Year	Fair Market Value	Amount Owed

HOUSEHOLD ASSETS - Does your household have any assets or joint accounts? No Yes → ATTACH PROOF OF CURRENT VALUE

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Cash | <input type="checkbox"/> Money market accounts | <input type="checkbox"/> Savings bonds, stocks or mutual funds | <input type="checkbox"/> Patient trust fund |
| <input type="checkbox"/> Checking account | <input type="checkbox"/> Christmas club accounts | <input type="checkbox"/> Land contract, mortgage or other note payable to household member | <input type="checkbox"/> Burial plot(s), casket, etc. |
| <input type="checkbox"/> Savings account | <input type="checkbox"/> Life Estate | <input type="checkbox"/> Tools and equipment, livestock or crops | <input type="checkbox"/> Burial trust/funeral contract(s) |
| <input type="checkbox"/> Credit union account | <input type="checkbox"/> Life insurance | <input type="checkbox"/> OTHER (list) | |
| <input type="checkbox"/> Real estate | <input type="checkbox"/> Certificate of deposit (CD) | <input type="checkbox"/> Expect money from a lawsuit in the next 30 days | |
| <input type="checkbox"/> IRA, KEOUGH, 401K or Deferred Comp. account(s) | | | |

Owner(s) of asset(s)	Type(s) of asset(s)	Balance amount or value	Name of bank, insurance company, etc.	Account/policy number
		\$		
		\$		
		\$		

*Please tell us if anyone has closed any accounts, sold or given away property, a vehicle, stocks, bonds, etc. How long ago? _____

*Has anyone filed a lawsuit or expect money in the next 30 days? No Yes → If yes, Explain _____

HOUSEHOLD INCOME - Does your household have any income? No Yes → Total monthly household income \$ _____

Please check **all** sources of income that your household expects to receive in the next 30 days. ATTACH PROOF

- | | | |
|---|---|--|
| <input type="checkbox"/> Social Security benefits | <input type="checkbox"/> Disability benefits | <input type="checkbox"/> Employment/earned income |
| <input type="checkbox"/> Supplemental Security Income (SSI) | <input type="checkbox"/> Self-employment income | <input type="checkbox"/> Worker's Compensation |
| <input type="checkbox"/> Pension/retirement benefits | <input type="checkbox"/> Unemployment | <input type="checkbox"/> Money from family/friends |
| <input type="checkbox"/> Veteran's benefits/Military allotments | <input type="checkbox"/> Child support | <input type="checkbox"/> Other, please list (ex: lottery winnings) |
| <input type="checkbox"/> Tribal payments (Energy Assistance/LIHEAP, tribal GA, casino/gambling profit sharing, land claims, etc.) | | |
| <input type="checkbox"/> Rental income or a land contract, mortgage or other payment payable to a household member | | |

Person With Income	Type of Income (if employed, name of employer)	Gross Monthly Income (amount before any expenses or taxes)	How often received?

*Please tell us if there have been any changes or if you expect a change in your household income in the next 30 days.

When did or will this change occur? _____

CURRENT HOUSING EXPENSES

Check all expenses you are required to pay	Monthly Expense	Name of your service provider, landlord, mortgage company, etc.	Account number	Is this a shared meter?	Is there theft or illegal use?	Name and address on bill or account
<input type="checkbox"/> Heat	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Electricity	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Water/sewer	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Cooking fuel	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Rent	\$					
<input type="checkbox"/> Mortgage	\$					
<input type="checkbox"/> Property Taxes	\$					
<input type="checkbox"/> Home insurance	\$					

Case Name	Case Number	Specialist
-----------	-------------	------------

HOUSEHOLD INFORMATION FOR THE PAST SIX MONTHS

Complete the chart below to tell us about your expenses, income and how many people live with you for the last six (6) months. If you did not have the expense, write "NONE" in the box.

	1 MONTH AGO	2 MONTHS AGO	3 MONTHS AGO	4 MONTHS AGO	5 MONTHS AGO	6 MONTHS AGO
Month						
# of people in home						
Total monthly income	\$	\$	\$	\$	\$	\$
Rent/Mortgage amount	\$	\$	\$	\$	\$	\$
Heat	\$	\$	\$	\$	\$	\$
Electricity	\$	\$	\$	\$	\$	\$
Water, Sewer & Cooking Gas	\$	\$	\$	\$	\$	\$

INCOME EXPENSES - Does your household pay any of the following? No Yes → Check all that apply and ATTACH PROOF.

<input type="checkbox"/> Health insurance premium \$	Paid how often?	Covers what time period (1mo., 3 mos., etc.)
<input type="checkbox"/> Court ordered child support (amount paid per month) \$		
<input type="checkbox"/> Actual child care costs paid by the employed person, not MDHHS		
<input type="checkbox"/> Unusual employment related expenses \$	Explain expense	

BURIAL - If you are applying for burial services, please complete this section. Be sure to answer income, vehicle and asset questions for the individual, his or her spouse or parent(s) of a minor child. ATTACH PROOF.

Name of deceased	Date of death	Is this a cremation? <input type="checkbox"/> No <input type="checkbox"/> Yes	Date of burial/cremation
Name of funeral home handling services	Address of funeral home		Phone # of funeral home
Place of burial/name of cemetery or crematory	Is payment to the cemetery or crematory separate from the payment to the funeral home? <input type="checkbox"/> No <input type="checkbox"/> Yes	Is there a memorial service? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Did you sign a statement of Goods and Services with the funeral home? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is the total cost of the burial/cremation? \$	Is the deceased a veteran? <input type="checkbox"/> No <input type="checkbox"/> Yes	
What is your legal relationship with the deceased?	Is there a contribution from family and/or friend? <input type="checkbox"/> No <input type="checkbox"/> Yes → Amount \$	Did the deceased own his or her home? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Indicate any death benefits applied for or expected to be received and the amount.		Address of home:	
<input type="checkbox"/> Accident/automobile insurance \$ _____	<input type="checkbox"/> Pre-paid funeral agreement \$ _____	If yes, is there a co-owner? <input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> Social Security death benefits \$ _____	<input type="checkbox"/> Veteran's death benefit \$ _____	Name of co-owner:	
<input type="checkbox"/> Life Insurance \$ _____	<input type="checkbox"/> A Community assistance fund/fraternal organizations \$ _____		
<input type="checkbox"/> Labor union benefits \$ _____	<input type="checkbox"/> Other benefit (specify source) \$ _____		

SIGNATURE REQUIREMENT

I understand failure to provide the above information may result in denial of my application. I understand I have **eight calendar days** to provide all verifications requested. I understand giving false information can result in referral to the prosecutor for fraud. I understand that my application may be one of those chosen for a complete investigation. A department representative may call at my home and may contact other people in order to verify my eligibility for assistance.

I authorize the department to release my name and address to the local weatherization operator as part of the Weatherization Referral system. I authorize the department to release case and payment information to the Michigan Department of Health and Human Services, its affiliates and/or contracted agencies, for the purpose of research, study and evaluation of the Low Income Home Energy Assistance Program (LIHEAP).

I authorize my energy company to release by phone, fax, email or their computer web site all available information about my account.

UNDER PENALTIES OF PERJURY, I SWEAR OR AFFIRM THAT THIS APPLICATION HAS BEEN EXAMINED BY OR READ TO ME. IF I AM A THIRD PARTY APPLYING ON BEHALF OF ANOTHER PERSON, I SWEAR THAT THIS APPLICATION HAS BEEN EXAMINED BY OR READ TO THE APPLICANT, UNLESS THE APPLICATION IS FOR A DECEASED PERSON. TO THE BEST OF MY KNOWLEDGE, THE FACTS ARE TRUE AND COMPLETE.

Signature of applicant or authorized representative	Date	Signature of spouse	Date
Current address		Signature of MDHHS specialist	Date
Current phone number		Identification of applicant or authorized representative	

Case Name	Case Number	Specialist
-----------	-------------	------------

Notes:

If you are not already registered to vote at your current address, would you like to register to vote? Yes No
NOTE: If you do not check either box, MDHHS will assume you have decided not to register to vote at this time. Checking "yes" does not register you to vote. If you check "yes" or do not respond, a voter registration application will be forwarded to you.

Applying or deciding to register to vote will not affect the amount of help that you will be provided by this department. 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 voter registration application form in private. If you believe that someone has interfered with your right to: register to vote, decline to register to vote, privacy in deciding whether to register or in applying to register to vote, or choose your own political party or other political preference, you may file a complaint with Michigan Secretary of State, PO Box 20126, Lansing, MI 48901-0726.

HEARINGS:

If you believe any action of the department is incorrect, or if the decision to approve or deny your application is not made within 10 (ten) days of the application date, you have the right to a hearing. A request for a hearing must be in writing, signed by you or your authorized representative, and received by the Michigan Department of Health and Human Services within 90 days following the date of this form. Hearing requests should be sent to your local MDHHS office in your area. You are entitled to representation by an attorney or other person of your choice. However, the department does not pay for any legal expenses.

Michigan Department of Health and Human Services (MDHHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an MDHHS office in your area.

AUTHORITY: Act 280, P.A. 1939, as amended (sections 400.6, 400.14, 400.24, 400.68 MCL); 45 CFR 283, 120(b); Low Income Home Energy Assistance Act of 1981, as amended; MCL 400.10; Administrative Codes Rules 400.7001-400.7049

COMPLETION: Required **PENALTY:** Denial of SER.