

Home Energy Assistance Program Cooling Assistance Request for Benefit

Applicant Information

Application Date: _____ Case Number: _____

Applicant Name: _____ SSN: _____

Address: _____ Telephone Number: _____

Does the applicant household contain an individual that has a medical condition that is worsened by extreme heat?

Yes- Please provide a note from a physician, physician assistant or a nurse practitioner documenting this condition dated within the twelve months prior to the month of application. The note must clearly state the health condition, and that the individual would benefit from the establishment of a cooling room or fan.

No

Agency Use Section

Did the applicant receive a Regular HEAP benefit in the current program year? Yes No

Has the applicant moved since receiving their Regular HEAP benefit? Yes No

Only answer the following if the Regular benefit was paid on a Temporary Assistance (TA) or Supplemental Nutrition Assistance Program (SNAP) case:

Has the TA or SNAP case closed since the applicant received their Regular HEAP benefit? Yes No

Pended Start: _____ End: _____

Denied Reason: _____

Approved Date: _____

Vendor Name: _____ Vendor Number: _____

Comments: _____

Worker Signature: _____

Date: _____

Supervisor Signature: _____

Date: _____