EOAC

Economic Opportunities Advancement Corporation
of Planning Region XI

Community Services Intake Application

REQUIRED DOCUMENTS:

- ☐ **COMPLETED Intake Application**
- ☐ **Proof of identity for every household member 18 years of age or older** *(ex: driver's license, current ID)*
- ☐ **Proof of citizenship for each household member** *(ex: birth certificate or passport)*
- ☐ **Proof of ALL income for the past 30 days for every household member 18 years of age or older, who** works or receives assistance.
  - Check stubs
  - Statement from employer (on company letterhead) showing gross income for the last 30 days
  - Self-Employed wages (complete Statement of Self-Employment Income form)
  - Award letters (TANF, SSI, Social Security, VA Benefits, Pension, etc.) for this current year
  - Unemployment Benefits (print out from TWC – Payment details by Week)
  - If no income has been earned/received, each household member 18 year and older must complete the Declaration of Income Statement on page 9.
    BANK STATEMENTS AND TAX DOCUMENTS ARE NOT ACCEPTED.
- ☐ **Current Electric Bill.** Provide a copy of the front and back of your most recent bill showing meter number and service address. If disconnect notice, provide disconnect bill and previous bill statement.
- ☐ **Current Gas/Propane Bill.** Provide a copy of the front and back of your most recent bill showing meter number, and service address. If disconnect notice, provide disconnect bill and previous bill statement.

PLEASE REMEMBER: Once the application is received with ALL supporting documents, it will be processed in the order it is received, and by **PRIORITY**. **Processing time can take up to 30 business days**. Failure to provide a completed application and all required documents will result in further delays. You are responsible for your utility bill payments at **ALL** times. Once the application is processed, you will be notified of the determination in writing. THIS IS NOT AN ENTITLEMENT PROGRAM. All assistance is subject to eligibility and the availability of funds.

ALL INCOMPLETE APPLICATIONS WILL BE SHREDDED.
EOAC IS NOT RESPONSIBLE FOR MAINTAINING ANY INCOMPLETE SUBMISSIONS.

****

Applications and all supporting documents may be returned in person, by mail, or fax.

- Address: 500 Franklin Ave, Waco, TX 76701
- Fax: (254) 756-7664

APPLICATIONS ARE NOT CURRENTLY ACCEPTED VIA EMAIL.

****

EOAC currently serves Bosque, Ellis, Falls, Freestone, Hill, Limestone, McLennan and Navarro counties.

This page must be completed in order for EOAC to determine how to provide assistance

Have you applied for Texas Utility Help? **RESPONSE REQUIRED** ☐ **YES** ☐ **NO**

What type of assistance are you applying for through EOAC ***(pleaae check all that apply)***

Electricty ☐

Gas ☐

Propane ☐

Case Management (vocational skills training, education assistance, job assistance,etc.) ☐

Other (please specify): _____ ☐

THIS IS NOT AN ENTITLEMENT PROGRAM. All assistance is subject to eligibility and the availability of funds.

Application for Assistance

Enter the information completely. PLEASE USE DARK BLUE OR BLACK INK. Failure to fill out the application completely, provide all the required documentation, and signatures will delay the processing of your application.

Client Number

APPLICANT INFORMATION

Applicant Last Name	Applicant First Name	Date	County
Physical Address	City	State	Zip
Mailing Address	City	State	Zip
Home Phone:	Cell/Alternate Phone:	Email:	

HOUSEHOLD INFORMATION - List head of household followed by all members living in the home

PLEASE USE THE CODES BELOW FOR COMPLETING PART 2

Race: White, Black, Asian, Multi, Native, No Answer

Health Insurance Source: Private, Employer, Medicaid, Medicare, Military, CHIP, none.

Military Status: Active Military, Veteran, Unknown

Self	Name: Last, First, MI			Social Security Number	Date of Birth	Race	Hispanic (Y/N)
	Disabled(Y/N)	Military Status	Education Level	Relationship to Applicant	Health Insurance Source	Age	Gender (M/F)
2	Name: Last, First, MI			Social Security Number	Date of Birth	Race	Hispanic (Y/N)
	Disabled(Y/N)	Military Status	Education Level	Relationship to Applicant	Health Insurance Source	Age	Gender (M/F)
3	Name: Last, First, MI			Social Security Number	Date of Birth	Race	Hispanic (Y/N)
	Disabled(Y/N)	Military Status	Education Level	Relationship to Applicant	Health Insurance Source	Age	Gender (M/F)
4	Name: Last, First, MI			Social Security Number	Date of Birth	Race	Hispanic (Y/N)
	Disabled(Y/N)	Military Status	Education Level	Relationship to Applicant	Health Insurance Source	Age	Gender (M/F)
5	Name: Last, First, MI			Social Security Number	Date of Birth	Race	Hispanic (Y/N)
	Disabled(Y/N)	Military Status	Education Level	Relationship to Applicant	Health Insurance Source	Age	Gender (M/F)
6	Name: Last, First, MI			Social Security Number	Date of Birth	Race	Hispanic (Y/N)
	Disabled(Y/N)	Military Status	Education Level	Relationship to Applicant	Health Insurance Source	Age	Gender (M/F)
7	Name: Last, First, MI			Social Security Number	Date of Birth	Race	Hispanic (Y/N)
	Disabled(Y/N)	Military Status	Education Level	Relationship to Applicant	Health Insurance Source	Age	Gender (M/F)
8	Name: Last, First, MI			Social Security Number	Date of Birth	Race	Hispanic (Y/N)
	Disabled(Y/N)	Military Status	Education Level	Relationship to Applicant	Health Insurance Source	Age	Gender (M/F)

INCOME SOURCES - List ALL income of adults and children that are 18 years of age or older for the last 30 days				
Identify income from any of the following sources:				
	Circle Yes or No		$ per Month	Times per Month
Salary from Employment	Yes	No		
Tips and Bonuses	Yes	No		
Commissions/Fees	Yes	No		
Recurring Gifts	Yes	No		
VA service connected	Yes	No		
VA non-service connected	Yes	No		
Alimony or other Spousal Support	Yes	No		
Interest/Dividends	Yes	No		
Social Security	Yes	No		
Supplemental Security Income (SSI)	Yes	No		
Social Security Disability Income (SSDI)	Yes	No		
Retirement Funds	Yes	No		
Pension	Yes	No		
Unemployment Benefits	Yes	No		
Workers Compensation	Yes	No		
TANF/AFDC	Yes	No		
Food Stamps	Yes	No		
Medicare/Medicaid	Yes	No		
Private Disability	Yes	No		
Child Support (anticipated, voluntary, court ordered) (regardless if paid)	Yes	No		
Other	Yes	No		

Non-Cash Benefits - Please identify income from any of the following sources					
Childcare Voucher	___Yes	___No	Affordable Care Act Subsidy	___Yes	___No
Housing Choice Voucher	___Yes	___No	HUD-VASH	___Yes	___No
LIHEAP	___Yes	___No	Permanent Supportive Housing	___Yes	___No
WIC	___Yes	___No	Other	___Yes	___No

HOUSING INFORMATION

Type: ___Private Home ___Mobile Home ___Apartment

Own: ___Yes ___No $_____per Month

Rent: ___Yes ___No $_____per Month

Utilities Included: ___Yes ___No

Landlord Name:_____Phone:_____

Landlord Address:_____City:_____State:____Zip:_____

HOUSEHOLD TYPE			
___Single Person	___Two Adults NO Children	___Single Parent Female	___Non-relative Adults w/Children
___Other	___Two Parent Household	___Single Parent Male	___Multigenerational Household

UTILITY INFORMATION		
Electric Service Provider:	Account #:	___Heating___Cooling___Both
Natural Gas Service Provider:	Account #:	___Heating___Cooling___Both
Propane Service Provider:	Account #:	___Heating___Cooling___Both
Water Service Provider:	Account #:	___Heating___Cooling___Both
Type of A/C: (circle one) Central Evaporative Window Unit None	Type of Heater: (circle one) Central Electric Heater Fire Place Space Heater Wall Furnace None	

PRIORITY INFORMATION		
	Circle One	
Is anyone in the household 60 years of age or older?	Yes	No
Is anyone in the household disabled?	Yes	No
Are there any children 5 years of age or younger in the household?	Yes	No

NEEDS ASSESSMENT

Please indicate what NEEDS you have below by writing either "Yes" or "No" in the box. If you write "Yes", please explain the need your experiencing so that we can help.

SERVICE	YES or NO	EXPLANATION	SERVICE	YES or NO	EXPLANATION
Basic Needs: Food, Clothing, Food Stamps, WIC, Meals on Wheels, Emergency, Other.			**Counseling**: Family, Alcohol, Substance Abuse, Gambling, Other.		
Income: SS, SSI, TANF, VA, Child Support, Budget, Other.			**Transportation**: To Work, Doctor, Car Repair, Bus Pass, Other.		
Employment: Looking for a job, Resume, Other.			**Veteran Needs**: Medical, Training, Home Repair, Handicap Access, Other.		
Utility Assistance: Electric, Gas, Water, Other.			**Legal Needs:** Child Support, Criminal, Civil, Other.		
Housing Needs: Temporary Shelter, Subsidized, Section 8, Repairs, Weatherization, Other.			**Health Needs:** Immunizations, Prescriptions, Primary Health Care, Mental Health Care, Other.		
Heating/Cooling: Heaters, Window Units, Repairs, Water Heater, Other.			**Education:** GED, English as a Second Language, Vocational, Other.		
Other Needs: Child Care, Elderly Care, Other.			**Other Needs not Identified on this Assessment.**		

CONFLICT OF INTEREST

1. Is anyone in the household currently serving as an employee, agent, consultant, officer or elected or appointed official of Economic Opportunities Advancement Corporation? YES / NO

If YES, identify who and their role _____

2. Is anyone in the household related to anyone currently serving as an employee, agent, consultant, officer or elected or appointed official of Economic Opportunities Advancement Corporation? YES / NO

If YES, identify who and their role _____

FOR OFFICE USE ONLY: If there is a Conflict of Interest, this application requires the Executive Director's Signature.

Program Director Signature:_____Date: _____

Executive Director Signature:_____Date: _____

CERTIFICATION AND RELEASE OF INFORMATION

1. The household information is true and correct to the best of my knowledge and belief.
2. I understand that my gross household income is annualized at the time of application, according to pre-established agency rules and procedures to receive assistance.
3. I understand that I may request a hearing to appeal a denial of eligibility, amount of assistance received, or a delay of service delivery.
4. I authorize the Texas Department of Housing and Community Affairs and its contracted agencies to contact any source in order to solicit/verify information on my utility and/or fuel bills, past and future necessary for an eligible determination.
5. I am an applicant of Economic Opportunities Advancement Corporation and give my permission to release and verify all information requested and understand that it will be kept in strict confidence and to be used for program purposes only. I understand that photocopies of this release are as valid as the original.
6. I give permission for pictures to be taken for identification purposes, projects, publication, newsletter, and promotional activities for Economic Opportunities Advancement Corporation. I give permission for my comments to be used in projects, publication, newsletter, and promotional activities for Economic Opportunities Advancement Corporation.
7. I understand that assistance is not guaranteed, and I will continue to make payments on my bills(s).
8. 8. **I UNDERSTAND THAT I AM SUBJECT TO PROSECUTION FOR PROVIDING FALSE OR FRADULENT INFROMATION**.

I certify that the information on this application is correct, and I also understand that receipt or assistance through misrepresentation or fraud is punishable by fine or imprisonment.

Applicant Signature:_____Date: _____

Case Worker Signature:_____Date: _____

Termination of Services Notice/ Aviso de Terminación de Servicios

Applicant Name /Nombre del Solicitante:

This notice is to inform you that you will be terminated from the CEAP/CSBG/WAP Program immediately for the following offenses if committed by you, the applicant, or any household member:

Este aviso es para informarle que se cancelará este programa inmediatamente por los siguientes delitos cometido por usted, el solicitante o cualquier miembro del hogar:

1. Belligerent or threatening behavior toward a staff member or any other person(s) while inside or outside any EOAC office.
   Comportamiento beligerante o amenazante hacia un miembro del personal o cualquier otra persona mientras dentro o fuera de cualquier oficina EOAC.
2. Verbal abuse, including the use of profanity at or in the presence of a staff member or any person(s), while inside or outside any EOAC office.
   Insultos a parte a oen presencia de un miembro del personal o cualquier otra persona(s) mientras que dentro o fuera de cualquier oficina EOAC.
3. Any type of actual physical confrontation toward a staff member or any other person(s) while inside or outside any EOAC office.
   Cualquier tipo de confrontación física real hacia un membro del personal o cualquier otra persona mientras dentro o fuera de cualquier ofician EOAC.
4. Providing a false or misleading information regarding any household member(s).
   Proporcionar false o engañosa información con respecto a cualquier miembro del hogar.
5. Theft from agency or staff member or any other person(s) while inside or outside any EOAC office. Theft is also identified as not returning EOAC funds refunded by an energy company.
   Proporcionar false o engañosa información con respecto cualquier miembro del hogar.
6. Violation of EOAC concealed and open carry handgun and firearm policy.
   Es una violación en EOAC llevar armas de fuego ocultas o ensenares una política.

I acknowledge that once terminated, I will not be allowed to reapply for any services with EOAC for a period of 1-2 years depending on the severity of the violation; and the ban from services will remain in effect even if the person(s) who committed the violation moves out.

I acknowledge that all documentation of the violation will be maintained in my client file, and that I shall have the right to appeal in writing to the Program Director within 10 days of the violation.

Reconozco que al finalizar, no se me permitirá volver a solicitar ningún servicio con EOAC porun período de 1 a 2 años, dependiendo de la gravedad de la infracción; y la prohibición de servicios seguirá en vigencia incluso si la (s) persona (s) que cometió la violación se mudan.

Reconozco que toda la documentación de la violación se mantendrá en mi archivo de cliente; y que tendré el derecho deapelar por escrito al Director del Programa dentro de los 10 días de la violación.

Applicant has a responsibility to / El solicitante tiene la responsabilidad de:

- Provide required information to verify eligibility for assistance whenever the case is opened or reopened. *Proporcione la información requerida para verificar la elegibilidad para recibir asistencia cada vez que se abra o se vuelva a abrir el caso.*
- Report any changes in the household – income, number of people in the home, etc. which may affect eligibility. *Informe sobre cualquier cambio en el hogar; ingresos, cantidad de personas en el hogar, etc. Que puedan afectar la elegibilidad.*
- Report any changes in utility provider when receiving utility assistance. *Informe cualquier cambio en el proveedor de servicios cuando recibe asistencia deutilidad.*

Client signature / Firma de cliente

Date / Fecha

TEXAS DEPARTMENT OF HOUSING AND COMMUNITY AFFAIRS
Household Status Verification Form

Systematic Alien Verification for Entitlements (SAVE) System and US Citizenship/US National

Applicant Certification Form for CEAP, DOE-WAP, LIHEAP-WAP Subrecipients, and SHTF, ESG, HHSP, EH (political subdivision only)

The program for which you are applying requires verification that you are a U.S. citizen, a non-citizen national, or a legal resident of the United States. Documentation of your status is required. This agency uses the Systematic Alien Verification for Entitlements (SAVE) System to verify the status of non-citizens.

Household Member Name	U.S. Citizen (Born or Naturalized) or U.S. National (Yes/No)	Qualified Alien (Yes/No)	Documentation Provided for:	
			Citizenship/Qualified Alien	Identification

To add additional household members, use another copy of this form.

I AM AWARE THAT I AM SUBJECT TO PROSECUTION FOR PROVIDING FALSE OR FRAUDULANT INFORMATION.

Applicant's Signature	**Date**

Signature of agency staff certifying they verified the above documents	**Print Staff Name**	**Date**

DECLARATION OF INCOME STATEMENT (DIS)
(DECLARACION DE INGRESOS)

Applicant Name (Nombre del Solicitante)	Applicant Last Name (Apellido)	Suffix (Sufijo)
Address (Dirección)	City (Ciudad)	Zip Code (Código Postal)

State the gross income for household members, 18 years and older, who have no documentation of the income received in the **30 day period** prior to the date of application for assistance: *(Declarar el ingreso recibido por los miembros de su hogar, que tienen 18 años de edad ó mas, y que no tienen documentación de ingresos por los 30 dias antes del aplicar para asistencia)*

Name (Nombre)	Gross Income Received (Ingreso Bruto Recibido)
Name (Nombre)	Gross Income Received (Ingreso Bruto Recibido)
Name (Nombre)	Gross Income Received (Ingreso Bruto Recibido)
Name (Nombre)	Gross Income Received (Ingreso Bruto Recibido)

My household has no documented proof of income due to the following situation *(Mi hogar no tiene prueba para documentar los ingresos por medio de tal razones):*

_____

_____

I certify that the above information is true and correct to the best of my knowledge and belief. *(Yo certifico que la información proveida de los ingresos es verdadera y correcta según mi saber y creencia.)*

I understand that the information will be verified to the extent possible; and that I may be subject to prosecution for providing false or fraudulent information. *(Comprendo que la información será verificada hasta donde sea posible y que puedo ser enjuiciado por haber proveido información falsa ó fraudulenta.)*

_____ _____

(Applicant Signature/Firma del Solicitante) *(Date/Fecha)*

Revised April 2023

Self-Certification of Disability

Applicant Name:

Name of Person with Disability:

Relationship of Person with Disability to Applicant:

Persons with Disabilities -- Any individual who is:

- A handicapped individual as defined in §7(9) of the Rehabilitation Act of1973;

- Under a disability as defined in §1614(a)(3)(A) or §223(d)(1) of the Social Security Act or in §102(7) of the Developmental Disabilities Services and Facilities Construction Act; or

- Receiving benefits under 38 U.S.C. Chapter 11 or 15

Applicant's Authorization to Declare Disabled Status:

I hereby authorize for the purpose of confirming my eligibility as a Person with Disability, in accordance with the above-stated definition of Person with Disability.

_____

Signature of Person with Disability or His/Her Guardian *Date*

Self-Certification of Life Threatening Crisis

Applicant Name:

Name of Person with Life Threatening Crisis:

Relationship of Person with Life Threatening Crisis:

Life Threatening Crisis as defined below (check all that apply):

□ Critical Care Patient: individual uses life-supporting medical equipment at home and termination of the utility service would be immediately life threatening.

□ Medical Emergency Patient: individual suffers from an existing medical condition that will be aggravated by the lack of utility service.

Applicant's Authorization to Declare Life Threatening Crisis Status:

I hereby certify that the information above is true and accurate; and that termination of utility services would be life threatening to those individuals.

_____

Signature of Applicant *Date*

EOAC Internal Referral Form

Please fill out the following information if you're interested in applying for other forms of assistance provided by EOAC. These programs will contact you directly when and if funding is available. Qualifications for each of these programs is different and may require additional information.

Name:

Address:

City/Zip:

Daytime Contact Number:

SERVICE	✓ **to request referral**
Heating/Cooling: Repairs or Replacement of Heaters, Window Units, etc.	
Weatherization: minor home repairs to prevent air from escaping or entering the home and save energy.	
Case Management (CSBG): Currently (or willing) to work on ways to increase household income. Willing to meet with Case Manager on a monthly basis. Qualified applicants could receive assistance with tuition, training, uniforms, etc.	
Head Start/Early Head Start: Childcare for ages 0-5, in McLennan and Falls County.	

FOR OFFICE USE ONLY: This is an internal referral form. CEAP Staff will scan and email to appropriate department (see SOP's for assistance).

Referral Sent By:_____Date Sent: _____

EOAC NEW CUSTOMER

APPLICATION FOR ENERGY/UTILITY ASSISTANCE

Thank you for your application.
Please allow 30 days for processing your application. Make sure you have included your current electric and gas bills.

IMPORTANT!!

THIS APPLICATION IS TO DETERMINE YOUR ELIGIBILITY FOR EXTENDED ASSISTANCE THROUGHOUT THE CALENDAR YEAR

APPROVAL: If you are eligible for services, you will receive a letter from EOAC describing the energy assistance available to you for the remainder of the year. Please note: You are responsible for all utility payments until you have received confirmation from our office.

DENIAL: You will be notified in writing if your application is incomplete, or your household is over the eligible income guidelines.

FUNDING PRIORITY: Please also be aware that applications are processed in the order they are received with priority given to households with elderly or disabled members, and with children under the age of five.

Because of the high volume of customers we serve daily, we please ask that you not contact our office to check on the status of your application. We will not be able to give you that information. Again, you will be notified in writing once it is processed.