APPLICATION FOR THE FLORIDA
LOW-INCOME HOUSEHOLD WATER ASSISTANCE PROGRAM (LIHWAP)

EXHIBIT 7

PLEASE FILL OUT APPLICATION COMPLETELY : Your LIHWAP application is not a commitment that your bill will be paid. If eligible, a credit will be sent directly to the utility vendor. However, you must continue to pay the amount owed on your bill.

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

Name (Include Last, First Middle Initial)	Date of Birth (MM/DD/YY)	Sex (M/F)	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*	Ethnicity*
Are you Disabled? ☐ **Yes** ☐ **No**		Do you receive Disability? ☐ **Yes** ☐ **No**		
If you are currently receiving Cash, Medical Assistance, or SNAP benefits, may we use the income you have on file? ☐ Yes ☐ No				

2 List the people who live with you at this address. Include all children and adults. Include related roomers.

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

CITIZENSHIP* : (1) U.S. Citizen/Nationalized, (2) Not U.S. Citizen/Alien lawfully admitted for permanent residence, (3) Cuban Entrant, (4) Lawfully Admitted Alien/Refugee, (5) Haitian Entrant, (6) Others.

RACE* : (1)American Indian/Alaskan Native, (2) American Indian/Alaskan Native & Black/African American, (3)American Indian/Alaskan Native & White, (4) Asian, (5) Asian & White, (6) Black/African American, (7) Black/African American & White, (8) Native Hawaiian/Pacific Islander, (9) Other Multi-Racial, (10) White, (11) Decline to Report.

ETHNICITY* : (1) non-Hispanic, (2) Hispanic

Name (Include Last, First, Middle Initial)	**Birthdate** (MM/DD/YY)	**Sex** M/F	**Social Security Number**	**Citizenship***	**Race***	**Ethnicity***	**Relationship to You**
Are you Disabled? ☐ **Yes** ☐ **No**				Do you receive Disability? ☐ **Yes** ☐ **No**			
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							

Name (Include Last, First, Middle Initial)	**Birthdate** (MM/DD/YY)	**Sex** M/F	**Social Security Number**	**Citizenship***	**Race***	**Ethnicity***	**Relationship to You**
Are you Disabled? ☐ **Yes** ☐ **No**				Do you receive Disability? ☐ **Yes** ☐ **No**			
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							

Name (Include Last, First, Middle Initial)	**Birthdate** (MM/DD/YY)	**Sex** M/F	**Social Security Number**	**Citizenship***	**Race***	**Ethnicity***	**Relationship to You**
Are you Disabled? ☐ **Yes** ☐ **No**				Do you receive Disability? ☐ **Yes** ☐ **No**			
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							

Name (Include Last, First, Middle Initial)	**Birthdate** (MM/DD/YY)	**Sex** M/F	**Social Security Number**	**Citizenship***	**Race***	**Ethnicity***	**Relationship to You**
Are you Disabled? ☐ **Yes** ☐ **No**				Do you receive Disability? ☐ **Yes** ☐ **No**			
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							

Name (Include Last, First, Middle Initial)	**Birthdate** (MM/DD/YY)	**Sex** M/F	**Social Security Number**	**Citizenship***	**Race***	**Ethnicity***	**Relationship to You**
Are you Disabled? ☐ **Yes** ☐ **No**				Do you receive Disability? ☐ **Yes** ☐ **No**			
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							

Name (Include Last, First, Middle Initial)	**Birthdate** (MM/DD/YY)	**Sex** M/F	**Social Security Number**	**Citizenship***	**Race***	**Ethnicity***	**Relationship to You**
Are you Disabled? ☐ **Yes** ☐ **No**				Do you receive Disability? ☐ **Yes** ☐ **No**			
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

3 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: (**Monthly Income, Monthly social Security Income, Monthly Alimony Income, Monthly Sate Reemployment Assistance, Monthly Pension Income, Monthly Workers Compensation Income, Monthly Self Employment Income, Monthly Supplemental Nutrition Assist (SNAP), Monthly Supplemental Security Income (SSI), Monthly Temp Assist for Needy Families (TANF), Monthly Means Tested Veteran Program and Other Monthly Income**):

Name of person with income	Type/source of income	How much each month?
Name of person with income	Type/source of income	How much each month?
Name of person with income	Type/source of income	How much each month?
Name of person with income	Type/source of income	How much each month?
Name of person with income	Type/source of income	How much each month?

4 What is your current housing status? ☐ Rent? ☐ Own this home?

5 Do you Live in a government subsidized housing complex, Section 8 housing, dormitory, nursing home, adult foster home or any kind of group living facility? **Yes☐** **No☐**

Name of the place where you live :
Address (Include Street, Apt. Number, City, State & ZIP Code:
County:

6 If your monthly income is less than 60% of the Florida state median income (SMI) (*Or if the number of your household members is nine (9) or greater,150% of the Federal poverty guidelines (FPG), explain how you pay for food, shelter, clothing, transportation, and home utilities.

7 Complete the following for your household:

Number of elderly persons (65 or older):	
Number of disabled persons:	
Number of children 5 years of age or younger:	

8 If you share your living or mailing address with others who are not part of your home, list their names

9 If you or anyone in your home are not a U.S. citizen or alien lawfully admitted for permanent residence, give the person's name and alien status under the Immigration and naturalization Act.

Name:	Alien Status:

10 You, or a member of my household, is currently receiving benefits from the Low- Income Home Energy Assistance Program (LIHEAP) **Yes ☐ No☐**

11 Do any of the following situations currently apply to you? (Check appropriate box(es) below)

- ☐ My water source has been disconnected
- ☐ I have received a notification that my water is going to be disconnected
- ☐ My water utility bill is delinquent or past due
- ☐ I need a deposit to turn the water on
- ☐ None of the above currently applies to my household
- ☐ Others (describe below)

12 If your cost of water/ wastewater services is included in your rent, give name and telephone number of your landlord. Attach a copy of a letter from the landlord confirming that your rent includes utilities.

Landlord Information:	Landlord Telephone Number:

13 Please Provide the requested information for the utility providers from which you are seeking assistance with.

Type of Utility Provider	Utility Company 's Name	Customer's Name on the Account	Customer's Account Number	Company's telephone Number	Disconnection Date	Payment Due Date
Drinking water & Wastewater (sewer)						
Drinking water only						
Wastewater (sewer) only						
Landlord						
Others						
Fines & Fees (Amount of fines or fees listed on utility bill or invoice due to non- payment of late payment)	$					
Arrearage (Amount of unpaid past due. Do not include fines or fees)	$					
Current Amount Due (Amount of current charges due, do not include any past due amount, fines or fees)	$					

14 **SUPPORTING DOCUMENTATION**: Please select the type of Documentation from the options below and attach a copy

- ☐ Current Water Utility Statement*
- ☐ Current Pay Stub or Proof of Income
- ☐ Current State Issued ID*
- ☐ Current wastewater(sewer) Utility Bill (if separates from water)
- ☐ Copy of Lease agreement (if Utility paid to property Management/Landlord)
- ☐ Others

FRAUD STATEMENT: The information above is, to the best of my knowledge, true and complete. I understand that priority in providing assistance will be given to those households with the lowest income and greatest need, i.e., those households in which the elderly, disabled, medical needy or children reside. I authorize the agency to make benefit payments directly to my Utility account. I am also aware that if I am not approved or denied within the time allowed, or not approved for the correct amount, I have a right to an appeal hearing.

APPEALS PROCESS:
Applicants have the right to appeal the decisions of the Administrating Agency.

1. An appeal must be submitted in writing within fifteen (15) calendar days of the completion of work or receipt of a decision in writing. An explanation should be provided detailing the nature of the specific complaint, or the problem with the work performed and why you believe it is not satisfactory. The appeal should be mailed to the attention of the community Action Agency LIHWAP Director.

2. The Subrecipient Agency LIHWAP Director will review your appeal and provide a written response via certified mail within fifteen (15) calendar days.

3. If you do not accept the above response, you may appeal to the chief Operations Officer (COO) in writing sent to the same address above within fifteen (15) calendar days of receiving the response.

4. The COO will review your appeal and provide a written response via certified mail within fifteen (15) calendar days. If you do not accept the above response, you may appeal to the Chief Executive Officer (CEO) in writing sent to the same address above within fifteen (15) calendar days of receiving the response.

5. The CEO will review your appeal and provide a written response via certifies mail within fifteen (15) calendar days.

6. If you do not accept the above response, you may appeal to the Board of Directors in writing sent to the same address above within fifteen (15) calendar days of receiving the response.

7. The Board of Directors or designated Board Committee (the Board) will review your appeal and provide written response via certified mail. The decision of the Board is the outcome of the appeal.

RECONSIDERATION:

A. Reconsideration means to re-evaluate eligibility, ineligibility, or the payment amount based on information that was unavailable or used incorrectly when the Agency decided eligibility.

B. DEO suggests a supervisory review when:

1. An Applicant received a denial notice; and,

   (a) The Applicant requested reconsideration within the required timeframe stated in the Notice of Denial and Appeals.
   (b) The Applicant requested reconsideration while funds remained.

2. An Applicant who is denied due to failure to provide requested information or verification submits the required information and funds remain.

3. An Applicant, who is denied, complains about the decision. In reviewing the case, staff finds the complaint has merit.

4. An Applicant, who is approved, complains about the amount of the benefit and the Agency finds that the payment was calculated incorrectly.

5. During case monitoring, it is found that the original decision (approval or denial) was possibly incorrect.

FAIR HEARINGS:
The LIHWAP is subject to current Fair Hearing processes as required.

NOTICE OF ADMINISTRATIVE RIGHTS:

ANY PARTY WHOSE SUBSTANTIAL INTERESTS ARE AFFECTED BY THIS DETERMINATION MAY INITIATE AN ADMINSTRATIVE PROCEEDING PURSUANT TO SECTION 120.569, FLORIDA STATUTES, BY FILING A PETITION.

A PETITION MUST BE FILED WITH THE AGENCY CLERK OF THE DEPARTMENT OF ECONOMIC OPPORTUNITY WITHIN 21 CALENDAR DAYS OF RECEIPT OF THIS DETERMINATION. A PETITION IS FILED WHEN IT IS RECEIVED BY:

AGENCY CLERK
DEPARTMENT OF ECONOMIC OPPORTUNITY
OFFICE OF THE GENERAL COUNSEL
107 EAST MADISON ST., MSC 110
TALLAHASSEE, FLORIDA 32399-4128
FAX- 850-921-3230
AGENCY.CLERK@DEO.MYFLORIDA.COM

YOU WAIVE THE RIGHT TO AN ADMINISTRATIVE PROCEEDING IF YOU DO NOT FILE A PETITION WITH THE AGENCY CLERK WITHIN 21 CALENDAR DAYS OF RECEIPT OF THIS DETERMINATION.

FOR THE REQUIRED CONTENTS OF A PETITION CHALLENGING AGENCY ACTION, REFER TO RULES 28-106.202(2), AND 28-106.301, FLORIDA ADMINISTRATIVE CODE.

DEPENDING ON WHETHER OR NOT MATERIAL FACTS ARE DISPUTED IN THE PETITION, A HEARING WILL BE CONDUCTED PURSUANT TO EITHER SECTIONS 120.569 AND 120.57(1), FLORIDA STATUTES, OR SECTIONS 120.569 AND 120.57(2), FLORIDA STATUTES.

PURSUANT TO SECTION 120.573, FLORIDA STATUTES, AND CHAPTER 28, PART IV, FLORIDA ADMINISTRATIVE CODE, YOU ARE NOTIFIED THAT MEDIATION IS NOT AVAILABLE.

NOTICE REGARDING COLLECTION OF SOCIAL SECURITY NUMBERS

The following disclosure is being made pursuant to section 119.071(5), Florida Statutes.

Social security numbers of applicants and household members are requested because this information has been determined to be imperative for the performance of the duties and responsibilities prescribed by law under the Low Income Household Water Assistance Program. This information is not required by state or federal law; however, social security numbers are necessary to determine eligibility for program services and specifically for the following purposes:

1. To verify an applicant's identity.
2. To verify household size.
3. To verify household income.

A social security number collected pursuant to this notice can only be used by the Florida Department of Economic Opportunity for the purposes specified above.

NONDISCLOSURE EXPECT UNDER LIMITED CIRCUMSTANCES:

Social security numbers will not be disclosed to others unless required or authorized by Florida law. Section 119.071(5), Florida Statutes, allows disclosure of a person's social security number under the following specific, limited circumstances:

- If disclosure is expressly required by federal or Florida law or is necessary for the agency or governmental entity to perform its duties and Responsibilities
- If the individual expressly consents to disclosure in writing.
- If disclosure is made to prevent and combat terrorism pursuant to the U.S. Patriot Act of 2001 or Presidential Executive Order 13224 (blocking property and prohibiting business transactions with persons who commit, threaten to commit, or support terrorism)
- For an agency employee and dependents, if disclosure is necessary to administer the person's health benefits or pension plan funds; or
- If disclosure is for the purpose of the administration of the Uniform Commercial Code by the office of the Secretary of State.

- If disclosure is requested by a commercial entity for permissible uses under the federal Driver's Privacy Protection Act of 1994, the federal Fair Credit Reporting Act, or the federal Financial Services Modernization Act of 1999 (for example, to verify the accuracy of personal information provided by the individual to the commercial entity; use by an insurer in connection with claims investigation or anti-fraud activities; for use in connection with a credit transaction).

ACKNOWLEDGMENT OF RECEIPT OF NOTICE:

☐ By checking this box, I confirm that I have been provided a copy of this Notice regarding the collection of my social security number and the social security numbers of all household occupants as part of the application process for the Florida LOW INCOME HOUSEHOLD ASSISTANCE PROGRAM.

☐ By checking this box, I hereby authorize the utility service company as provided in the application to disclose pertinent information regarding my account to agencies that may provide me financial assistance, including the Florida LIHWAP office. I understand and acknowledge the purpose of this disclosure is solely for federal reporting purposes and does not determine my eligibility for assistance. I further acknowledge and understand that the utility company provided within this application may be conserved confidential. I also understand and acknowledge that the named utility does not and will not have control over my account information provided to agencies pursuant to this acknowledgement and authorization. I will hold the utility company harmless for any claim related to the account information provided. This agency may verify information contained in the payment assistance application, including the utility account for which I am seeking assistance.

☐ By checking this box, I certify that all information entered by me in this application, as well as any attachments or supplemental information provided, are true and accurate to the best of my knowledge.

APPLICANT SIGNATURE :	**DATE :**
CASEWORKER :	**DATE :**
SUPERVISOR/EDIT STAFF:	**DATE :**