MARTIN COUNTY HUMAN SERVICES
435 SE FLAGLER AVE., STUART, FL 34994
Phone: 772-288-5786 Fax: 772-223-4829

FPL Electric Assistance Application

Thank you for contacting the Martin County Board of County Commissioners Community Services Program to request to request assistance. This packet includes basic information outlining the documentation that you **must provide to be considered for assistance**.

Once you have collected the required documentation listed below, please call **(772) 288-5785** for an appointment. If you do not qualify for assistance, you may call and inquire as to the reason(s) for denial.

Eligibility Criteria

- Must be a Martin County resident
- Must have a past-due balance or final notice bill from FPL
- Applicant must prove they are below income threshold in Table 1.1 (shown on pg. 2)
- Must have a crisis that prevented payment of the bill and a plan for paying the next bill
- $500 maximum assistance limit
- Qualified applicants can only receive assistance from this program once every 12 months

Required Documents

Please make sure you **bring originals or copies of the following documentation** in order to determine program eligibility:

- Picture identification for all adults in the household, 18 years of age or older.
- Social Security Cards for all household members.
- Proof of current employment (pay stubs for the last 30 days, or if new hire, letter from employer indicating rate of pay and hours to be worked)
- Copies of official documentation showing **ANY and ALL** other income, such as Child Support, Social Security, Unemployment, Worker's Compensation, Food Stamps, etc.
- Proof of crisis *(i.e. – medical bill, receipt of car repair, etc.)*
- FPL electric bill *(must be past-due or a final notice bill and account must be in the name of someone living in the household)*

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED

†The completion of this form does not guarantee that Martin County will be responsible for the cost of requested goods/services. Final approval shall be determined by staff of the Martin County Community Services Program in accordance with program guidelines.

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INCOME GUIDELINE

Income in this case means gross wages, and certain unearned income such as Social Security Benefits, Alimony, etc. Total gross income must be below threshold in Table 1.1 based on your household composition to qualify and is based on the last 30 days.

Table 1.1: Income Guideline thresholds by family type (proxy) and FPL Region

FPL Region	County	Single Adult (annually)	Family (annually)	Senior 60+ (annually)
East	Indian River Martin Okeechobee Palm Beach St. Lucie	$25,464	$74,460	$28,224

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Applicant Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Email: _____

*Please list ALL household members. Income is calculated based on **gross income** (before deductions), please use exact numbers.*

Household Members	Social Security Number	Relationship	Sex	Disabled	Veteran	DOB	Age	Monthly Income	Income Source	Migrant Worker
		HOH	M F	Y N	Y N					Y N
			M F	Y N	Y N					Y N
			M F	Y N	Y N					Y N
			M F	Y N	Y N					Y N
			M F	Y N	Y N					Y N
			M F	Y N	Y N					Y N
			M F	Y N	Y N					Y N
			M F	Y N	Y N					Y N
			M F	Y N	Y N					Y N
			M F	Y N	Y N					Y N

Household Size: _____

Total Monthly Income: _____ x 12 = Annual Household Income: _____

By signing below, you certify that all information provided is accurate to the best of your knowledge.

Applicant Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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Describe **in detail** the reason you are unable to afford your electric bill this month.
Also, please **list all agencies** that you have attempted to get assistance from to pay your electric bill.

Describe **in detail** how you plan to pay future electric bills if you receive assistance this month.

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CLIENT CONSENT FOR DATA COLLECTION AND RELEASE OF INFORMATION

This client notice and consent describes how information about you may be used and collected for the purpose of providing the service you have applied for and how you can have access to this information. In order for a service to be provided, this form **MUST** be signed.

I, _____, understand and acknowledge that Martin County Human Services uses a digital client tracking system and I consent to and authorize the collection and retention of my information for the purpose of the service(s) I am applying for. I understand that such information may include, but is not limited to the following:

- Identifying information (name, birth date, gender, race, social security number, residential information, phone number, family information, etc.)
- Financial information (income verification, public assistance payments and allowances, food stamp allotments, etc.)
- Medical records (HIV/AIDS diagnosis, psychological records and evaluations, vocational assessments, care coordinators recommendations/direct observation, employment status, etc.)
- Substance abuse diagnosis, treatment plans, progress in treatment, and discharge information
- Other (As specified in the space provided) _____

  _____

Additionally, please review the following bullet points:

- I understand that Martin County Human Services may contact my employer, bank, family/friends, or any other institution(s) or person(s) to verify information and confirm my eligibility for the program(s) I am applying for.
- I understand that I have the right to inspect, copy, and request all records maintained by the County relating to the provision of services to me and to receive a paper copy of this form.
- I understand that this release can be revoked by me at any time and that the revocation must be signed and dated by me. If not previously revoked, this consent terminates automatically **ONE YEAR** after this form has been signed.
- I understand that my records are protected by Federal, State, and local regulations governing confidentiality of client records and cannot be disclosed without my written consent, unless otherwise provided for in regulations.

_____ _____

Client Signature Date

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This document may be reproduced upon request in an alternative format by contacting the County ADA Coordinator (772) 288-5400, Florida Relay 711, or by completing our accessibility feedback form at www.martin.fl.us/accessibility-feedback.

Authorization for Release of General and/or Confidential Information For FPL Payment Assistance Qualification (specific to FPL Care To Share®)

(Revised April 2 2021)

Note: The Applicant must sign this form authorizing the agency to use the Florida Power & Light (FPL) ASSIST process in qualifying the FPL account for payment assistance. **Refusal to sign this form may lead to disqualification.** The Applicant may appeal this requirement by speaking to the agency Director/Manager, as the agency deems appropriate. The agency Director/Manager may opt to contact FPL to discuss any confidentiality concerns the Applicant may have regarding the application/qualification process.

FPL ACCOUNT HOLDER (CUSTOMER NAME): _____

SERVICE ADDRESS FOR FPL (INCL. CITY/ST/ZIP): _____

FPL ACCOUNT NUMBER: _____ **PHONE FOR FPL ACCOUNT HOLDER:** _____

SECTION A: APPLICANT READS AND COMPLETES THIS SECTION ONLY IF HE/SHE **IS THE ACCOUNT HOLDER**

I hereby authorize FPL and this agency to disclose pertinent information to related community agencies. I understand that the need or purpose of this disclosure is solely to facilitate the assistance qualification process.

All information is accurate to the best of my knowledge. The agency may verify information contained in the payment assistance application, including the FPL account for which I am seeking assistance. I also confirm that I have not received FPL Care To Share Program assistance in the past twelve months from the date of this application, at this or any other FPL service address.

ACCOUNT HOLDER'S SIGNATURE: _____ **DATE:** _____

SECTION B: APPLICANT READS AND COMPLETES THIS SECTION ONLY IF HE/SHE **IS NOT THE ACCOUNT HOLDER**

As applicant for payment assistance for the above-referenced FPL account, I hereby confirm that I am not the Account Holder with FPL, but I am authorized by the Account Holder to initiate this assistance application on his/her behalf. This may be confirmed at the agency's discretion, by contacting the Account Holder.

All information is accurate to the best of my knowledge. The agency may verify my personal information contained in this authorization, including the FPL bill account for which I am seeking assistance. I also confirm that I have not received FPL Care To Share Program assistance in the past twelve months from the date of this application, at this or any other FPL service address.

APPLICANT'S NAME (NOT ACCOUNT HOLDER): _____

APPLICANT'S PHONE NUMBER: _____

APPLICANT'S SIGNATURE: _____ **DATE:** _____

SECTION C: FOR AGENCY USE ONLY

Agency must maintain this form in the applicant's file and make this form available to FPL upon request, for accounting and auditing purposes.

AGENCY NAME: _____ **PHONE:** _____

AGENCY CASEWORKER'S NAME (*PLEASE PRINT*): _____

AGENCY CASEWORKER'S SIGNATURE: _____ **DATE:** _____

☐ **FPL ASSIST REP NAME:** _____ **OR** ☐ **NO CALL, USED FPL ASSIST PORTAL**

THIS APPLICANT SATISIFIES:

1. **ALL ELIGIBILITY CRITERIA AS OUTLINED IN THE FPL CARE TO SHARE PROGRAM GUIDELINES. CHECK HERE:** ☐
2. **THE PROGRAM'S INCOME ELIGIBILITY GUIDELINES BASED ON EITHER (CHECK ONLY ONE OF THE OPTIONS LISTED BELOW):**

☐ **150% < OF POVERTY LEVEL OR** ☐ **QUALIFIED USING APPROVED ALICE CRITERIA**

COMMUNITY SERVICES BLOCK GRANT
Customer Satisfaction Survey

The purpose of this survey is to provide feedback to improve services offered.
Please answer the survey in its entirety.

1. **What is your name?** *(Optional)* _____

2. **What county do you live in?**
   - ☐ St. Lucie County
   - ☐ Martin County
   - ☐ Okeechobee County

3. **Please select which services you received from our agency?**
   - ☐ Assistance applying for Benefits
   - ☐ Childcare Assistance
   - ☐ Home Health Assistance
   - ☐ Household Items
   - ☐ ID Assistance or related
   - ☐ Rental/Utility Assistance
   - ☐ Transportation Assistance
   - ☐ Education Assistance
   - ☐ Other: _____

4. **How would you rate the quality of service you have received?**
   - 4 ☐ Excellent
   - 3 ☐ Good
   - 2 ☐ Fair
   - 1 ☐ Poor

5. **Did you get the kind of service you wanted?**
   - 1 ☐ No, definitely not
   - 2 ☐ No, not really
   - 3 ☐ Yes, generally
   - 4 ☐ Yes, definitely

6. **To what extent has our program met your needs?**
   - 4 ☐ Almost all of my needs
   - 3 ☐ Most of my needs
   - 2 ☐ Only a few of my needs
   - 1 ☐ None of my needs

7. **If a friend were in need of similar help, would you recommend our program to them?**
   - 1 ☐ No, definitely not
   - 2 ☐ No, I don't think so
   - 3 ☐ Yes, I think so
   - 4 ☐ Yes, definitely

8. **How satisfied are you with the amount of help you received?**
   - 1 ☐ Quite dissatisfied
   - 2 ☐ Mildly dissatisfied
   - 3 ☐ Mostly satisfied
   - 4 ☐ Very satisfied

9. **Have the services you received helped you deal more effectively with your problems?**
   - 4 ☐ Yes, greatly
   - 3 ☐ Yes, somewhat
   - 2 ☐ No, not really
   - 1 ☐ No

10. **Over all, how satisfied are you with the services you have received?**
    - 4 ☐ Very satisfied
    - 3 ☐ Mostly satisfied
    - 2 ☐ Mildly dissatisfied
    - 1 ☐ Quite dissatisfied

11. **If you were to seek help again, would you come back to our program?**
    - 1 ☐ No, definitely
    - 2 ☐ No, I don't think so
    - 3 ☐ Yes, I think so
    - 4 ☐ Yes, definitely

Thank you for participating in our survey. Your feedback is important.