# Martin County Health and Human Services

435 SE Flagler Avenue
Stuart, FL 34994
Ph: (772) 320-3204
Fax: (772)223-4829


Thank you for contacting the Martin County Board of County Commissioners Community Services Program to request to be placed on a sliding scale fee for testing. 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) 320-3204** for an appointment. If you do not qualify for assistance, you may call **(772) 320-3204** and inquire as to the reason(s) for denial.

Please make sure you **bring 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** other income, such as Child Support, Social Security (SSI, SSDI), TANF, Alimony, Unemployment, Worker's Compensation, Food Stamps, etc.
- Electric bill (must be past due or final notice bill, must be in the name of someone living in the household)
- Proof of crisis, i.e. medical bill, receipt of car repair, etc.

## INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED

# ELECTRIC ASSISTANCE APPLICATION

## INCOME GUIDELINE

**2020 Poverty Guidelines Effective January 14, 2020**
**(Based on Gross Income)**

| Number in Household | 100% | 125% | 150% | 175% | 185% | 200% |
|---|---|---|---|---|---|---|
| 1 | $12,760.00 | $15,950.00 | $19,140.00 | $22,330.00 | $23,606.00 | $25,520.00 |
| 2 | $17,240.00 | $21,550.00 | $25,860.00 | $30,170.00 | $31,894.00 | $34,480.00 |
| 3 | $21,720.00 | $27,150.00 | $32,580.00 | $38,010.00 | $40,182.00 | $43,440.00 |
| 4 | $26,200.00 | $32,750.00 | $39,300.00 | $45,850.00 | $48,470.00 | $52,400.00 |
| 5 | $30,680.00 | $38,350.00 | $46,020.00 | $53,690.00 | $56,758.00 | $61,360.00 |
| 6 | $35,160.00 | $43,950.00 | $52,740.00 | $61,530.00 | $65,046.00 | $70,320.00 |
| 7 | $39,640.00 | $49,550.00 | $59,460.00 | $69,370.00 | $73,334.00 | $79,280.00 |
| 8 | $44,120.00 | $55,150.00 | $66,180.00 | $77,210.00 | $81,622.00 | $88,240.00 |
| | For each additional person add: | | | | | |
| | $4,480.00 | $5,600.00 | $6,720.00 | $7,840.00 | $8,288.00 | $8,960.00 |

Income in this case means gross wages, and certain unearned income such as Social Security Benefits, Alimony, etc. Total gross income must be less than 150% based on your household size to qualify and is based on the last 30 days.

# ELECTRIC ASSISTANCE APPLICATION

**Applicant Name: _____ Date: _____**

**Address: _____ City: _____ Zip: _____**

**Phone: _____ Email: _____**

Please list **ALL** household members. Income is calculated based on gross, 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**: _____

**Applicant Signature: _____ Date: _____**

**Staff Signature: _____ Date: _____**

**By signing you certify that all information provided is accurate to the best of your ability.**

# ELECTRIC ASSISTANCE APPLICATION

Describe **in detail** in the space below the reason you are unable to pay your electric bill this month**.**

Describe **in detail** in the space below how you plan to pay for future electric bills if you are assisted with your bill this month.

## 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 Health and 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 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)
- Financial information (income verification, public assistance payments and allowances, food stamp allotments)
- Medical records (except HIV/AIDS and alcohol/ drug treatment), Psychological records and evaluations, vocational assessment, care coordinators recommendations and direct observation, employment status, etc.
- HIV/AIDS Diagnosis
- Substance abuse diagnosis, treatment plan, progress in treatment, discharge.
- Other_____ (As specified in the space provided)

Additionally, please review the following bullet points.

- I understand that Martin County Health & Human Services may contact my, employer, bank, family/friends, or any other institutions or persons to verify information and confirm my eligibility for the program I am applying for.
- I understand that I have the right to inspect, copy and request all records maintained by the Agency 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 the 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

**Martin County Health and Human Services**
**435 SE Flagler Ave, Stuart, FL 34994**
**P: 772-288-5786 F: 772-223-4829**

# 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.**