Opportunities for Williamson & Burnet Counties
OWBC-TX.ORG

MEALS ON WHEELS | HEAD START | COMMUNITY SERVICES | AFFORDABLE HOUSING

Our Mission: To make our communities stronger by empowering children, families and seniors to achieve independence and improved quality of life

2020 Community Services Intake Application

READ ALL SECTIONS CAREFULLY
ALL APPLICATIONS MUST BE COMPLETE TO BE PROCESSED

ALLOW UP TO 90 DAYS FROM THE ENTRY OF THE COMPLETE APPLICATION FOR PROCESSING

- Requests are processed on the received order and may be processed by priority rating scale
- Account holder will be responsible for the cost of energy, including late fees that occur until notified
- Absence of supporting documents will cause a delay in processing or denial of the application
- The applicant is notified by mail, email and/or telephone with respect to the assistance or additional information needed
- Applications are valid thru December of each current calendar year.
- Applicants can apply yearly as early as January of each current calendar year.

TWO Community Services Programs Available:

1. Long Term Energy Assistance Program - CEAP– Assistance with energy cost. Eligibility for low-income residents. This program could aid with multiple months as determined by qualifications. Applicants will be notified of assistance provided for the year. Additional energy assistance may be available as funds and eligibility allow.

2. Self-Sufficiency Program - CSBG – Coaching Assistance with gaining education and or increased job skills in order to increase wages from employment. Low income families or individuals will receive coaching, guidance and family support long term in order to reach their ultimate goals in becoming self-sufficient. Case Managers assist in removing barriers to success.

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MEALS ON WHEELS · HEAD START · COMMUNITY SERVICES · EQUAL HOUSING OPPORTUNITY AFFORDABLE HOUSING

2020 INTAKE APPLICATION

Community Services Programs Available:

❖ LONG TERM ENERGY ASSISTANCE PROGRAM - CEAP

❖ SELF-SUFFICIENCY PROGRAM – CSBG

Failure to provide a complete application and accurate documentation could result in a denial

Item Needed	Energy Assistance Program CEAP	Self Sufficiency Program CSBG
PROVIDE PROOF OF ALL INCOME	Proof of ALL current income from the last 30 days for ALL members of the household. *See Pg. 6*	Proof of ALL current income from the last 30 days for ALL members of the household. *See Pg. 6*
PROVIDING PROOF OF IDENTITY • *Pleasecallforalternate documents at 512-255-2202*	• If Over 18 yrs. or older - State issued ID or DL • If Under 18 yrs. – Valid Parent ID match to Birth Certificate. *See pg. 2* *ALL Adults and children, extended family, friends, roommates, etc. LIVING in the home.*	• Proof of Identity for the Applicant ONLY when applying for Self Sufficiency Program.
PROVIDE PROOF OF CITIZENSHIP or LEGAL RESIDENCE For Each Household Member (Including minors)	Citizenship verification *See pg. 2* • Us Passport • State Issued Birth Certificate • Permanent Residence Card	
Systematic Alien Verification (SAVE)	Save Form must be completed, signed and proof of ID and Citizenship or Legal Residence provided. *See pg. 2*	
PROVIDING UTILITY BILLS	Current energy bill with balance	
ADDITIONAL INCLUDED FORMS Declaration of Income (DIS) Self-Identification of Disability (SID) Vendor Release	Use DIS form ONLY for members needing alternate documentation of Income. *See pg. 7* Use SID form ONLY for members not receiving Federal disability benefits. *See pg. 8* Use Vendor Release form ONLY for services provided by: ATMOS/ RELIANT/ AUSTIN ENERGY	Use DIS form ONLY for members needing alternate documentation of Income. *See pg. 7* Use SID form ONLY for members not receiving Federal disability benefits. *See pg. 8*
Ensure your application and documents are complete and legible. You may picture, scan or copy needed documents to include with your application		
Submit Options:	Email: Utilities@owbc-tx.org	604 High Tech Drive, Georgetown Texas 78626 / Fax 512 763 1411

Circle the program(S) for which you are applying: CEAP CSBG

Applicant First Name _____ Middle Name _____ Last Name _____

Physical Address _____ Apt/Suite _____ City _____ Zip _____ County _____

☐ Mailing Address is Same as Physical Address

Mailing Address (Address, City, Zip) _____

Print Email Address _____ Primary Ph Number _____ Primary Language _____

How did you hear about us? ☐ Previous Client ☐ Website ☐ Social Service Agency ☐ Referred by OWBC Staff ☐ Other

Alternate Contact - It is important that we can reach the applicant for additional items needed regarding the application.

Name	Relationship	Phone

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REQUIRED DOCUMENT FOR APPLICATION

See pg. 1 for Instructions

PROVIDE INFORMATION FOR ALL HOUSEHOLD MEMBERS

TEXAS DEPARTMENT OF HOUSING AND COMMUNITY AFFAIRS

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 subvision 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	Qualified Alien (Yes/No)	Documentation Provided for:	
			Citizenship	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 Above	**Date**

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

Updated March 2019
Previous Versions Obsolete

HOUSEHOLD MEMBERS INFORMATION – Required for every member of the household including adults and minors, extended family, friends, roommates, etc. living in the home. Complete the information below. Incomplete applications could be denied.

1. Applicant Member Name:	Date of Birth: _____/_____/_____ Month/Day/Year	Gender: Male Female Other	Disability Status: Yes No	Military Status: Active Military Veteran
Relationship to Applicant: Self Spouse Child – Birth / Step / Foster Parent / Stepparent Grandparent Aunt/Uncle Sibling Other Relative Guardian Friend	Race: Am Indian/Alaskan Native Asian Black/African American Multi-Race Native Hawaiian Other Pacific Islander White Other Ethnicity: Hispanic / Latino Non-Hispanic/ Non- Latino	Type of Health Insurance: Direct -Purchase Employment Based Medicaid Medicare Military Healthcare State Children Health Ins Program (CHIP) State Health Insurance for Adults	Education Status Current or Up To: Grades 0-8 Grades 9-12 Graduate: HS/GED Post-Secondary 2 to 4 Year College	Current Work Status Employed: Full Time Part Time Retired Migrant-Seasonal Worker Unemployed: Long Term > 6 months Short Term < 6 months Not in Labor Force Minor Child
2. Member Name (if applicable)	Date of Birth: _____/_____/_____ Month/Day/Year	Gender: Male Female Other	Disability Status: Yes No	Military Status: Active Military Veteran
Relationship to Applicant: Self Spouse Child – Birth / Step / Foster Parent / Stepparent Grandparent Aunt/Uncle Sibling Other Relative Guardian Friend	Race: Am Indian/Alaskan Native Asian Black/African American Multi-Race Native Hawaiian Other Pacific Islander White Other Ethnicity: Hispanic / Latino Non-Hispanic/ Non- Latino	Type of Health Insurance: Direct -Purchase Employment Based Medicaid Medicare Military Healthcare State Children Health Ins Program (CHIP) State Health Insurance for Adults	Education Status Current or Up To: Grades 0-8 Grades 9-12 Graduate: HS/GED Post-Secondary 2 to 4 Year College	Current Work Status Employed: Full Time Part Time Retired Migrant-Seasonal Worker Unemployed: Long Term > 6 months Short Term < 6 months Not in Labor Force Minor Child
3. Member Name (if applicable)	Date of Birth: _____/_____/_____ Month/Day/Year	Gender: Male Female Other	Disability Status: Yes No	Military Status: Active Military Veteran
Relationship to Applicant: Self Spouse Child – Birth / Step / Foster Parent / Stepparent Grandparent Aunt/Uncle Sibling Other Relative Guardian Friend	Race: Am Indian/Alaskan Native Asian Black/African American Multi-Race Native Hawaiian Other Pacific Islander White Other Ethnicity: Hispanic / Latino Non-Hispanic/ Non- Latino	Type of Health Insurance: Direct -Purchase Employment Based Medicaid Medicare Military Healthcare State Children Health Ins Program (CHIP) State Health Insurance for Adults	Education Status Current or Up To: Grades 0-8 Grades 9-12 Graduate: HS/GED Post-Secondary 2 to 4 Year College	Current Work Status Employed: Full Time Part Time Retired Migrant-Seasonal Worker Unemployed: Long Term > 6 months Short Term < 6 months Not in Labor Force Minor Child

IMPORTANT INFORMATION FOR FORMER MILITARY SERVICES MEMBERS:
Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Coast Guard, Reserves or National Guard, may be eligible for additional benefits and services. For more information please visit the Texas Veterans Portal at https://veterans.portal.texas.gov/.

HOUSEHOLD MEMBERS INFORMATION – Required for every member of the household including adults and minors, extended family, friends, roommates, etc. living in the home. Complete the information below. Incomplete applications could be denied.

4. Member Name (if applicable)	Date of Birth: _____/_____/_____ Month/Day/Year	Gender: Male Female Other	Disability Status: Yes No	Military Status: Active Military Veteran
Relationship to Applicant: Self Spouse Child – Birth / Step / Foster Parent / Stepparent Grandparent Aunt/Uncle Sibling Other Relative Guardian Friend	Race Am Indian/Alaskan Native Asian Black/African American Multi-Race Native Hawaiian Other Pacific Islander White Other Ethnicity Hispanic / Latino Non-Hispanic/ Non- Latino	Type of Health Insurance Direct -Purchase Employment Based Medicaid Medicare Military Healthcare State Children Health Ins Program (CHIP) State Health Insurance for Adults	Education Status Current or Up To: Grades 0-8 Grades 9-12 Graduate: HS/GED Post-Secondary 2 to 4 Year College	Current Work Status Employed: Full Time Part Time Retired Migrant-Seasonal Worker Unemployed: Long Term > 6 months Short Term < 6 months Not in Labor Force Minor Child
5. Member Name (if applicable)	Date of Birth: _____/_____/_____ Month/Day/Year	Gender: Male Female Other	Disability Status: Yes No	Military Status: Active Military Veteran
Relationship to Applicant: Self Spouse Child – Birth / Step / Foster Parent / Stepparent Grandparent Aunt/Uncle Sibling Other Relative Guardian Friend	Race Am Indian/Alaskan Native Asian Black/African American Multi-Race Native Hawaiian Other Pacific Islander White Other Ethnicity Hispanic / Latino Non-Hispanic/ Non- Latino	Type of Health Insurance Direct -Purchase Employment Based Medicaid Medicare Military Healthcare State Children Health Ins Program (CHIP) State Health Insurance for Adults	Education Status Current or Up To: Grades 0-8 Grades 9-12 Graduate: HS/GED Post-Secondary 2 to 4 Year College	Current Work Status Employed: Full Time Part Time Retired Migrant-Seasonal Worker Unemployed: Long Term > 6 months Short Term < 6 months Not in Labor Force Minor Child
6. Member Name (if applicable)	Date of Birth: _____/_____/_____ Month/Day/Year	Gender: Male Female Other	Disability Status: Yes No	Military Status: Active Military Veteran
Relationship to Applicant: Self Spouse Child – Birth / Step / Foster Parent / Stepparent Grandparent Aunt/Uncle Sibling Other Relative Guardian Friend	Race Am Indian/Alaskan Native Asian Black/African American Multi-Race Native Hawaiian Other Pacific Islander White Other Ethnicity Hispanic / Latino Non-Hispanic/ Non- Latino	Type of Health Insurance Direct -Purchase Employment Based Medicaid Medicare Military Healthcare State Children Health Ins Program (CHIP) State Health Insurance for Adults	Education Status Current or Up To: Grades 0-8 Grades 9-12 Graduate: HS/GED Post-Secondary 2 to 4 Year College	Current Work Status Employed: Full Time Part Time Retired Migrant-Seasonal Worker Unemployed: Long Term > 6 months Short Term < 6 months Not in Labor Force Minor Child

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Complete the information below. Incomplete applications could be denied.

HOUSING INFORMATION

Circle and Provide the following information

Own: No Yes Mortgage per month:_____

Rent: No Yes Rent per month:_____

Type: Private Home Apartment/ Duplex Mobile Home Rented Room

Do you participate in Subsidized/Public Housing? No Yes – What Type? _____

Utilities Included: No Yes

UTILITY SERVICE VENDOR INFORMATION

Please mark (✓) for yes and Provide the following information

How does your family pay for utilities? ☐ To Utility Company ☐ To Landlord ☐ Included in Rent

				Primary Use	Primary Use
Electric Utility Company/Vendor:		Acct No.		☐ Heating	☐ Cooling
Gas Utility Company/Vendor:		Acct No.		☐ Heating	☐ Cooling
Propane Company/Vendor:		Acct No.		☐ Heating	☐ Cooling
Other Energy Company/Vendor:		Fuel Type:		☐ Heating	☐ Cooling
Type of Air Conditioning Used:	☐ Central Unit	☐ Evaporator Cooler	☐ Window Unit	☐ None	
Type of Heater Used:	☐ Central Electric Unit ☐ None	☐ Natural Gas	☐ Propane	☐ Wood/Fireplace	

HOUSEHOLD NEEDS ASSESSMENT

Please mark (✓) yes for any immediate needs or requests for services

EMERGENCY SERVICES	✓	OWBC SERVICES	✓
Food Pantry - Referral		Daily Meal Delivery or Daily Onsite Lunch - Seniors 60 Yrs. and up (Meals on Wheels)	
Child Care - Referral		Early Childhood Education ages 0- up to 3 (Early Head Start) ages 3-5 (Head Start)	
Weatherization … Reducing energy cost by increasing energy efficiency of the home - Referral		Energy Assistance Program (Community Services)	
Clothing Closet - Referral		Extended Self Sufficiency Program (Community Services) *See Below:*	
Transportation – Medical Visits Transportation, Local Bus information, Share Ride - Referral		Assistance with obtaining Adult Education for – ESL, GED, Short-Term Certifications, Reaching associate degree or bachelor's degree	
Assistance with obtaining - SSDI, TANF, WIC, SS, SSI, VA, Child Support, etc. - Referral		Assistance with obtaining Employment	
Housing - Temporary, Short-Term, Long-Term - Referral			

Complete the information below. Incomplete applications could be denied.

HOUSEHOLD INCOME SOURCES

Provide the most current documentation from ALL household member income sources for Adults and Children in the last 30 days		**Office Use ONLY** Gross Income		
Current Last 30 days Income Source	Household Member Name	Y	N	MONTHLY $
Salary from Employment - • Employer Paystubs • Docs showing name, pay date and gross $ amount				
Tips and Bonuses				
Commissions/Fees				
Recurring Gifts				
Veteran Benefits- Service or Non-Service				
Alimony				
Interest/Dividends				
Supplemental Security Income (SSI)				
Social Security Disability Income (SSDI)				
Social Security (SS) (Retirement)				
Retirement Security Disability Income (RSDI)				
Retirement Funds				
Pension				
Unemployment Benefits				
Worker's Compensation				
TANF – Temp Asst for Needy Families				
Food Stamps / SNAP				
General Assistance				
EITC – Earned Income Tax Credit				
Private Disability Insurance				
Child Support: Yes No Anticipated Voluntary Court Order (regardless if Paid)				
Other				

Provide the most current documentation as listed above as coverage within the last 30 days.

Declaration of Income Statement

Applicant First Name	Middle Name	Last Name

Physical Address	Apt/Suite	City	Zip	County

By signing below – The Applicant certifies these household members are without income or have exhausted the ability to provide acceptable documentation of income for the reasons listed below:

*This form is ONLY for household members, 18 years old or older. If a member can show proof of income via paystub, award letter etc., this form is not needed.

Names of Household Member(S) *NO Income or ability to provide acceptable proof of income*	Dates – Last 30 days	Gross Amount Received	Circle the Reason for No Income or No Documentation
	From / / To / /	$	• Recently unemployed Last Pay Date:________________ • Disabled – Not Receiving Benefits • Primary full-time caregiver for disabled adult • Primary full-time caregiver for disabled child • Not able to affordable childcare • Not able to obtain transportation to maintain employment • Not able to provide proper documentation showing member name, Gross Amt, Pay dates, Employer information • Other:________________
	From / / To / /	$	• Recently unemployed Last Pay Date:________________ • Disabled – Not Receiving Benefits • Primary full-time caregiver for disabled adult • Primary full-time caregiver for disabled child • Not able to affordable childcare • Not able to obtain transportation to maintain employment • Not able to provide proper documentation showing member name, Gross Amt, Pay dates, Employer information • Other:________________
	From / / To / /	$	• Recently unemployed Last Pay Date:________________ • Disabled – Not Receiving Benefits • Primary full-time caregiver for disabled adult • Primary full-time caregiver for disabled child • Not able to affordable childcare • Not able to obtain transportation to maintain employment • Not able to provide proper documentation showing member name, Gross Amt, Pay dates, Employer information • Other:________________

I certify that the above information is true and correct to the best of my knowledge and belief. If any part is false, my participation in this agency's program may be terminated, and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Office Use Only

Valid:

____
Signature of Applicant

Self-Identification of Disability

Applicant – Disabled household members, *NOT receiving disability cash benefits provided by the federal government*, may self-identify as disabled by reviewing and the Acts and benefits below in order to attest. This form MUST be signed by the disabled household member or guardian.

Applicant's Name _____

Name of Person with Disability _____

Relationship of Person with Disability to Applicant _____

Person with Disability is any individual who is:

- A handicapped individual as defined in §7(9) of the Rehabilitation Act of 1973;
- 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.

I hereby authorize the above-mentioned individual, for the purpose of confirming eligibility as a Person with Disability, is in accordance with the above-stated definition of Person with Disability.
I certify that the above information is true and correct to the best of my knowledge and belief. If any part is false, my participation in this agency's program may be terminated, and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Office Use Only

Valid: _____

_____
Signature of Person with Disability or His/Her Guardian

OWBC offers its SELF-SUFFICIENCY PROGRAM to qualifying applicants.

Case Management is NOT required in order to qualify for Long Term Energy Assistance program

It is designed to assist families to become self-supporting through entering the workforce with greater job and life skills. Families work one on one with a case manager and tailor a service plan unique to the family's needs and barriers to getting back to work.

Program Requirements		Program Benefits
➢ Resident of Williamson or Burnet County		➢ Case manager provides wrap-around coaching methods specific to your family's needs
➢ Income-Based program		➢ Activities and services guided by you to achieve your goals
➢ Desire to be challenged		➢ Multi-layered support by utilizing agencies and resources available in your area
➢ Willingness to make a change		➢ Receive measurable outcomes to success
➢ Commitment to take the steps necessary to become self-sufficient		➢ Achieve Self-Sufficiency

Below are a few things to consider when deciding if this program is right for your family:

- ☐ Are you ready to get back to work?
- ☐ Are you wishing you had greater skills for a career?
- ☐ Are you looking for an advocate to assist you in obtaining skills to prepare you for a career?
- ☐ Are you willing to do what it takes to achieve?
- ☐ Have you taken steps to reach your goals?
- ☐ Are you aware of your main challenges?
- ☐ Have you reached out for assistance?
- ☐ Are you ready for success?

Case Managers are available Monday – Friday 8am to 5pm with exception to holidays.

Would you like a Case Manager to contact you regarding the Self-Sufficiency Program? Yes No

CEAP and/or CSBG APPLICATION AUTHORIZATION *Read BEFORE signing this document

1. The information is true and correct to the best of my knowledge and belief.
2. I understand that my household gross (pre-tax) income has been annualized, at the time of application, according to pre-established agency procedure.
3. I am aware that I am subject to prosecution for providing false or fraudulent information on this application. I also understand that receipt or assistance through misrepresentation or fraud is punishable by fine or imprisonment.
4. I understand that I may request a hearing to appeal a denial of eligibility, amount of assistance received, or a delay in service delay.
5. I authorize the Texas Department of Housing and Community Affairs and Opportunities for Williamson and Burnet Counties, Inc. to solicit/verify information including utility and/or fuel bills (if applying for utility assistance) and employment verification, both past and future, to the extent that the information is used only to determine eligibility and provide data.
6. I am an applicant of Opportunities for Williamson and Burnet Counties, Inc. I hereby give my permission to release and verify all information requested and understand that it will be kept in strict confidence to be used for program purposes only. I understand that a photocopy of this release is as valid as the original and may be used to obtain employment information or verify other data.
7. I understand that if I move residents or change utility companies, I must notify Opportunities for Williamson and Burnet Counties, Inc. within 5 business days with my new utility company, account number, and name on the account. If I do not notify Opportunities for Williamson and Burnet Counties, Inc. of my new utility company I will lose any payments due. When the information is provided any remaining assistance may be reinstated. (If applying for utility assistance)
8. I understand that if my current monthly bill exceeds the payment agreement for that month that I am responsible for the remaining balance owed to the vendor. Should I be disconnected for failure to pay any remaining balance owed to the vendor, I will be terminated from the Utility Assistance program, and this agreement becomes null and void. (If applying for utility assistance)

Applicant Signature	Staff Signature OFFICE USE ONLY	Office Use Only – Valid

For Austin Energy Customers Only

If you have questions, please call (512) 494-9400

Release of Customer Information Authorization Form

PURPOSE: This Release of Customer Information Authorization Form allows a City of Austin utility account holder ("Account Holder") to delegate certain rights to an authorized party ("Authorized Party") concerning account holder's service(s), including authorizing receipt of confidential customer account information. This form must be completed in its entirety and signed by the Account Holder or by someone who has legal authority to bind the Account Holder.

AUTHORIZATION: I,_____*(printed name)*, state that I am the City of Austin ("City") utility services Account Holder and hereby request and authorize the City to release my utility customer account information to:

Authorized Party: Opportunities for Williamson & Burnet Counties

Address: 604 High Tech Dr., Georgetown, TX 78626

Phone Number: 512-255-2202 Fax Number: 512-763-1411

Email Address: utilities@opportunitiesforwbc.org

The scope of access to my account information is authorized as follows:
(Account Holder must initial Restricted or Unrestricted)

_____Limited Access — Authorized Party may do the following: *(check any or all that apply)*

- ☐ Usage and Financial Information Only
- ☐ Usage and Financial Access
- ☐ Facilities / Property Management Access
- ☐ Account Manager

Other: _____

_____Full Access — Authorized Party may conduct any transactions and receive any information regarding my utility service account.

This authorization is valid for:
(Account Holder must initial)

_____One-time only-Authorized Party is granted access one time.

_____One year period-Authorized Party is granted access for twelve months from the date of execution of this form.

_____Date specific-Authorized Party is granted access until (date).

_____Account closes-Authorized Party is granted access until the utility account is closed.

*** If no time period is specified, authorization will be limited to a one-time authorization**

I request that the City provide information to the Authorized Party in the format checked below, but I understand the City will provide the information in the format it deems most appropriate.
(check all that apply)

- ☐ Hard copy via US Mail *(if applicable)* *604* High Tech Dr., Georgetown, TX 78626
- ☐ Facsimile to telephone number: 512-763-1411
- ☐ Electronic mail to email address: utilities@opportunitiesforwbc.org
- ☐ On-Line Customer Care Access: _____
- ☐ Telephone at: 512-255-2202 or 512-763-1400

I understand that this Authorization does not require the City to release information, and the City retains the right to verify any authorization request submitted before releasing information or taking any action.

I hereby release, hold harmless, and indemnify the City from any liability, claims, demands, and causes of action, damages, or expenses resulting from:

1) any release of information pursuant to this Authorization;
2) the unauthorized use of this information by the Authorized Party; and
3) any actions taken by the Authorized Party pursuant to this Authorization.

I understand that I may cancel this Authorization at any time by notifying the City in writing. I acknowledge I am signing this Authorization under my own free will and not under duress. I certify that the authorized party does not benefit from utilities at the service address listed.

Account Holder's Signature _____ Date: _____

Account Holder's Printed Name _____

Account Holder's Identification:

Social Security Number ..... _____

or Driver's License Number _____

or Tax Identification Number _____

or Other Identification Number _____

Utility Service Address: _____

Utility Service Account Number: _____

Account Holder Daytime Phone Number: _____

For Reliant Energy Customers Only

Authorization for Online Access of Account Information with Reliant Energy, Inc.

I, the undersigned Reliant Energy customer ("Customer"), hereby authorize The Energy Assistance Agency ("Agency"), to obtain online access to my Reliant Energy account information for the purpose of obtaining my 12-month billing history, 12-month payment history, and account balance ("Account Information") to be used for the sole purpose of determining my eligibility for participation in or benefits with the Agency.

I understand that the Account Information obtained by the Agency may contain personal or personally-identifying information, and that the Agency (and not Reliant Energy) is solely responsible for the confidentiality and security of the information obtained on my behalf.

Customer Name (Print)

Customer Signature

Service Address

Date:

Energy Assistance Agency: Opportunities for Williamson & Burnet Counties, Inc.

For Atmos Energy Customers Only

MAACLink

CLIENT CONSENT AND RELEASE OF INFORMATION

MAACLink is a computer system that is used locally as a Homeless Management Information System (HMIS). Use of an HMIS is required by the US Department of Housing and Urban Development (HUD) for agencies that receive HUD funding. MAACLink is not electronically connected to HUD and is only used by authorized agencies. All MAACLink users have received confidentiality training and have signed strict agreements to protect clients' personal information and limit its use appropriately.

A Privacy Notice is available at participating agencies. It provides details on how member agencies and their employees handle client information and data sharing.

I give permission to _____(Agency Name) to collect and enter my personal and household information into the MAACLink computer system.

I understand that the MAACLink system is shared with and used by authorized agencies in my community for the purposes of:

1. Assessing the needs of low-income, homeless or other special-needs people in order to give better assistance and to improve their current or future situations.
2. Improving the quality of care and service for people in need.
3. Tracking the effectiveness of community efforts to meet the needs of people who have received assistance.
4. Reporting data on an aggregate level that does not identify specific people or their personal information.

I understand that:

- Information I give about my physical or mental health will NOT be shared outside the agency I am working with.
- I have the right to view my MAACLink file with an authorized user.
- Signing this release form does not guarantee that I will receive assistance.
- I may revoke my authorization by completing a revocation form.
- All agencies that use MAACLink will treat my information with respect and in a professional and confidential manner.
- Unauthorized people or organizations cannot gain access to my information without my consent.
- If I receive services from Homeless Prevention Rapid Re-Housing Federal Stimulus (HPRP) Funds, my information may be viewed by other participating agencies across Continuums of Care.

Client Name (Printed)	Client Signature	Date
Agency Representative Name (Printed)	Agency Representative Signature	Date