Dear Friend,

In response to the increased awareness of the effects of extreme weather on Medically vulnerable individuals, The Heat and Warmth Fund (THAW) is pleased to introduce the **"iHEAL Families"** program. iHEAL is an innovative utility assistance program, in partnership with DTE Energy, to provide utility assistance and wraparound services to patients with health conditions.

1. Review the 2017 Program Guidelines to see if you meet eligibility requirements.

2. Complete the iHEAL application and include copies of supporting documents *(refer to the Document Checklist).*

Once THAW receives your completed application, it will be reviewed and an approval or denial letter will be mailed to your home. If you are approved and enrolled you will pay a fixed monthly amount for your utilities, and the program will pay the difference between the plan amount and your monthly bill.

Submit your application to THAW:

Mail or In-Person: The Heat and Warmth Fund
535 Griswold, Suite 200
Detroit, MI 48226

In-Person: Mercy Primary Care Center
at the Samaritan Center
5555 Conner St, Suite 2691
Detroit, MI 48226

We are here to help. If you have questions or want to check on your application status, call 1-800- 866-THAW (8429) to speak to a THAW utility assistance specialist.

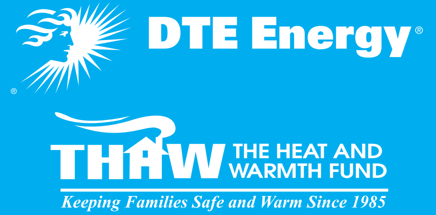
Thank you,

Saunteel Jenkins
Chief Executive Officer
The Heat and Warmth Fund

THAW iHEAL FAMILIES

In Partnership With:

DTE LOW INCOME SELF-SUFFICIENCY PLAN (LSP)



AN AFFORDABLE MONTHLY PAYMENT PLAN

- Enroll in DTE Energy's LSP plan.
- Once enrolled you will pay a fixed monthly amount for your utilities, and **the program will pay** the difference between the plan amount and your monthly bill.
- Other program benefits include access to dedicated Customer Advocates, self-sufficiency training, protection from shutoff, no future late payment charges and the reduction of your outstanding balance.
- Any three missed payments during the year will result in plan termination.
- To qualify, income must be equal to or less than 150 percent of the Federal Poverty Level (FPL) Guidelines (see chart below).

. You must not have used more than $2500 in natural gas for the year, $2000 in electricity for the year or $4500 in both natural gas and electricity.

***Must have an active service and no unauthorized usage.**

***Arrears must not exceed $2,800.**

HOW TO APPLY:

- Fill out this application
- Send this completed application (starting with page 3) by mail to:
  The Heat and Warmth Fund
  535 Griswold, Ste 200
  Detroit, MI 48226

For information phone: 877.410.0612
(Mon – Fri 8:30 a.m.- 5:30 p.m)

Website: thawfund.org

FAMILY SIZE	MAXIMUM MONTHLY HOUSEHOLD INCOME (150% POVERTY LEVEL)
1	$1,485.00
2	$2,002.50
3	$2,520.00
4	$3,037.50
5	$3,555.00
6	$4,072.50
7	$4,591.25
8	$5,111.25

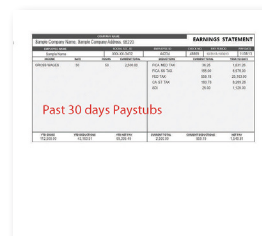
*For each additional household member add $520

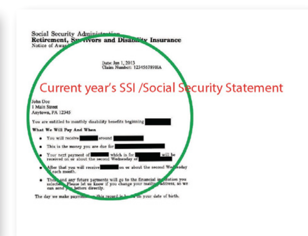
ALLOW 10 DAYS FOR PROCESSING A COMPLETED APPLICATION

APPLICATION CHECKLIST

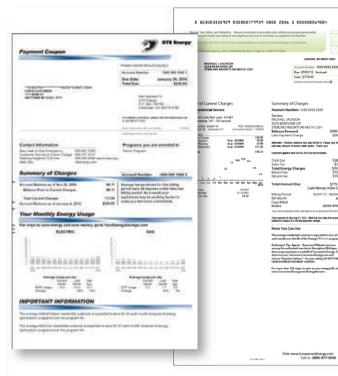
- ❒ Must be 18 years or older to apply
- ❒ All pages of the application must be completed & returned to THAW.
- ❒ Application must be signed and dated by the DTE Energy account holder.
- ❒ Account holder must provide valid copies of their ID and Social Security Card.

- ❒ **Address on ID must match the service address of the account.** If not, you must provide another document validating the address for the account holder/applicant.





- ❒ **Proof of all household income,** Child Support, Unemployment, Cash Assistance, (FIP), Adoption Subsidy/Direct Care, Worker's Compensation, Alimony, Interest Annuities or Dividends, Self-employment
- ❒ Copy of your DTE Energy utility bill that you are seeking assistance for



If needed, complete the Medical Emergency Hold Request Form. Please ensure section 3 is signed by a physician or public health official (such as a licensed nurse, registered nurse, physician's assistant, etc).

Any incomplete applications will delay the 10-day processing period

i HEAL LOW INCOME SELF-SUFFICIENCY PLAN (LSP)

DTE Energy

Any incomplete applications will delay the 10-day processing period

First Name _______ Middle Initial _______ Last Name _______

( ) Phone _______ ( ) Other _______ ( ) Alternate Contact Number _______

Mailing Address _______ City _______ State _______ ZIP _______

Service Address _______ City _______ State _______ ZIP _______
Supply Service Address if mailing address is different

County _______ Email _______

ATTACH EXTRA PAGES IF YOU NEED TO INCLUDE ADDITIONAL MEMBERS. List **EVERYONE** who lives in your home, including adults and children temporarily absent due to illness or employment. People are considered members of your household if they sleep and keep their belongings in your home. Be sure to include the date of birth and citizenship status for each member.

List All Household Members including Self First, Middle Initial and Last Name	Relationship to Applicant	Date of Birth	Social Security Number (All Nine Digits Required)	Disabled (Circle Answer)	Are you a U.S. Citizen?
	SELF			Yes / No	Yes / No
				Yes / No	Yes / No
				Yes / No	Yes / No
				Yes / No	Yes / No
				Yes / No	Yes / No
				Yes / No	Yes / No
				Yes / No	Yes / No

YOU MUST ANSWER ALL QUESTIONS

What are your total utility cost for the month?	$	
Do you own or rent your home?	Own	Rent
Is any household member a veteran?	Yes	no
Have you received energy assistance from THAW in the past?	Yes	no
Have you or do you currently receive benefits from Department of Health and Human Services?	Yes	no
Have you received energy assistance from another agency since October 1, 2016?	Yes	no

If yes, Name of Agency: _______ Date _______

How do you heat your home?: ❒ Natural Gas ❒ Propane ❒ Electric Heat ❒ Wood ❒ Fuel Oil ❒ Coal
❒ Other (explain)

Home Heating Credit: Did you receive a Home Heating Credit in the last 6 months? ❒ Yes Month Received _______ ❒ No

Reasons for needing assistance (Check all that apply):

❒ Low-Income Household ❒ Job Loss ❒ Medical Hardship ❒ Other (explain):

I have taken the following steps to reduce energy use and energy costs (check all that apply):

❒ Use CFL/LED Bulbs
❒ Lowered water heater setting
❒ Weather-strip or wrap windows/doors in plastic
❒ Lower thermostat temperature
❒ Turn off lights and electronics
❒ None of the above
❒ Lower thermostat when away

Assistance is not dependent upon your response.

i HEAL LOW INCOME SELF-SUFFICIENCY PLAN (LSP)

DTE Energy Service(s) with which you need help

Account #:
Name on Account:

Emergency Need

**Electric heat sources include solar panels, boilers, radiators, or baseboard heating but DO NOT include space heaters*

Check the service(s) that you are requesting and the amount needed to resolve the emergency for 30 days:	❒ Household Heating $ __________________ If this is a prepaid account, amount in account $ __________________
	❒ Electricity (non-heating) $ __________________ If this is a prepaid account, amount in account $ __________________

Has your heat been turned off?	❒ Yes, date heat was turned off:	❒ No
Have you received a past due or shut off notice for your heat?	❒ Yes, date service is scheduled to be shut off:	❒ No
Has your electric been turned off?	❒ Yes, date turned off:	❒ No
Have you received a past due or shut off notice for your electricity?	❒ Yes, date service is scheduled to be shut off:	❒ No

Please check all sources of income that your household expects to receive in the next 30 days: (Please attach proof)

Does any member of your household have income? ❒ Yes, Total monthly income $ ❒ No

❒ Social Security	❒ Disability Benefits	❒ Employment/Earned Income
❒ Supplemental Security Income (SSI)	❒ Self-employment Income	❒ Worker's Compensation
❒ Pension/Retirement Benefits	❒ Unemployment	❒ Money from Family/Friends
❒ Veteran's Benefits/Military Allotments	❒ Child Support	

❒ Other (ex: lottery winnings) please list

❒ Tribal payments (Energy Assistance/LIHEAP, tribal Gaming Association, casino/gambling profit sharing, land claims, etc.)

❒ Rental Income or a land contract, mortgage or other payment payable to a household member.

Person with Income	Type of Income (If employed, name of employer)	Gross Monthly Income (Amount before taxes and expenses	How Often Received? (Weekly, biweekly, monthly, etc.)

Have there been any changes or do you expect a change in your household income in the next 30 days?	❒ No ❒ Yes, please briefly explain below: ______________________________ ______________________________

i HEAL LOW INCOME SELF-SUFFICIENCY PLAN (LSP)

Eligible income expenses

Does anyone in your household pay any of the following expenses? If yes, check all that apply and attach proof. ❐ Yes ❐ No

❐ Health insurance premiums	Amount $	How often paid?	Covers what time period?
❐ Court-ordered child support (paid)	Amount $	How often paid?	Covers what time period?
❐ Out-of-pocket childcare costs (not by DHHS)	Amount $		
❐ Unusual employment related expenses	Amount $	Explain expense	

Tell us what other resources you would be interested in learning about

❐ Access to technology ❐ Disability information ❐ Case management services ❐ Education
❐ Food ❐ Rent/mortgage assistance ❐ Health care access ❐ Transportation
❐ Employment ❐ Other: ______________________

Case Management Services Questionnaire

THAW is requesting your completion of this questionnaire. Your responses will help us learn more about what you or members of your household may need in order provide you access to services that may provide additional resources for your household. THAW can connect you to resources or services in your area through our partner agencies.

Please check all areas for preferred assistance/wraparound services:

❐ Clothing assistance
❐ Employment & Job Training
❐ Food pantry assistance
❐ Free Tax Preparation
❐ Disease Prevention
❐ Rental & Mortgage assistance
❐ Transportation assistance
❐ Weatherization
❐ Youth programming
❐ Daycare & Early childhood education
❐ Family Budgeting
❐ Mental Health Counseling
❐ Tutoring
❐ Education
❐ Emergency medical or financial assistance
❐ First Time Home Buying & Affordable housing
❐ Meals on wheels
❐ Other______________________

1.) What is your preferred form of communication regarding wraparound services/programming? (check one)

❐ Telephone______________________ ❐ Email ____________________@_____________.________

2.) What other feedback would you like to provide on this needs assessment questionnaire?

____

About You (optional)

Name ______________________________________ Gender: ❐ Male ❐ Female

Age group: ❐ 18-25 ❐ 26-35 ❐ 36-55 ❐ 56-65 ❐ over 65

County of residence______________________________

Thank you for your participation!

Signature Requirement

Please sign below after reading the following information, otherwise this application will be considered incomplete

- I understand I have eight calendar days to provide all verifications requested and failure to provide the above information may result in denial of my application. I understand giving false information can result in referral to the prosecutor for fraud. I understand that my application may be one of those chosen for a complete investigation. An agency or department representative may call my home and may contact other people in order to verify my eligibility for assistance.

- I authorize the assisting agency or provider to release my name and address to the local weatherization operator as part of the Weatherization Referral system. I authorize the department to release case and payment information to the Department of Health and Human Services, its affiliates and/or contracted agencies, for the purpose of research, study and evaluation of the Low Income Home Energy Assistance Program (LIHEAP).

- I authorize my energy company to release all available information about my account by phone, fax, email or their computer website.

- UNDER PENALTIES OF PERJURY, I SWEAR OR AFFIRM THAT THIS APPLICATION HAS BEEN EXAMINED BY OR READ TO ME. IF I AM A THIRD PARTY APPLYING ON BEHALF OF ANOTHER PERSON, I SWEAR THAT THIS APPLICATION HAS BEEN EXAMINED BY OR READ TO THE APPLICANT TO THE BEST OF MY KNOWLEDGE, THE FACTS ARE TRUE AND COMPLETE.

Signature of applicant or head of household ____________ Date ____________ Signature of spouse ____________ Date ____________

Address (Numbers & Street Name, Apt, etc.) ____________ Signature of agency representative ____________ Date ____________

Current phone number ____________ Identification of applicant or authorized representative ____________

iHEAL MEDICAL EMERGENCY HOLD REQUEST

DTE Energy

ADDITIONAL INFORMATION – *REVIEW CAREFULLY*

According to the Michigan Public Service Commission Consumer Standards and Billing Practices for Electric and Gas Residential Service, a customer may provide a signed medical emergency hold request to postpone the discontinuance or restore of utility service. A medical emergency hold request states that a customer requires, or has a household member that requires, home medical equipment, a life support system or a medical emergency as defined and certified by a physician or public health official.

If a customer submits a medical emergency hold request signed by a physician or public health official, along with the additional required information listed below, DTE Energy will suspend shutoff action for 21 days. Services will be restored, where applicable. The customer may be charged a deposit or restoration fees to the account for service restoration due to disconnection for non-payment.

Approval of the Medical Emergency Hold request does not guarantee an uninterrupted, regular, or continuous power supply. If utility service is a necessity, you must make other arrangements for on-site back-up capabilities or other alternatives in the event of loss of service.

The medical emergency hold request approval does not prevent shut-offs indefinitely.

Some of the equipment types that are considered medical equipment or a life support system:

Aerosol tent	Heart monitor	Pressure breathing treatment
Apnea monitors	Home dialysis treatment	Pressure pads and pumps
Compressor / Concentrator	IPPB machine	Respirator
Electronic nerve stimulator	Iron lung	Suction machine
Electrostatic nebulizer	Motorized wheelchairs	Ultrasonic nebulizer
Feeding or infusion (pump) machine	Oxygen concentrators	Ventilator

NOTE: CPAP & BPAP machines for adult sleep apnea do not normally qualify

Each Medical Hold request requires submission of valid identification for both the customer of record and the patient.

If the Patient is	Valid Identification Documentation Required
Customer	✔ Valid current identification for the customer, matching household address
Adult patient[1]	✔ Valid current identification for the customer, matching household address ✔ Valid current identification for the patient, matching household address
Minor patient in the household	✔ Valid current identification for the customer, matching household address ✔ Valid current identification for the parent/guardian of the minor, if different than the customer, matching household address ✔ Birth certificate for the minor, or current guardianship papers or state identification for the minor

(1) If the customer has multiple residential accounts and does not live at the same address as the patient, valid identification of the customer must be submitted matching one of the account addresses and valid identification of the patient must be submitted matching the second account address. The medical hold will only be placed at the address of the patient.

iHEAL MEDICAL EMERGENCY HOLD REQUEST

Section 1: To be completed by the customer (Account Holder)		
Customer Name - Last	First	Middle
Complete address of home where medical hold is being requested		
Work Phone	Home/Cell Phone	Home Email
DTE Energy Account Number		
I certify that the information provided above is accurate and that the patient is the DTE Energy customer of record or a family member of the customer residing at this residence.		
Customer Signature		**Date**

Section 2: To be completed by the individual needing the Medical Hold (the "Patient") or, if under 18-years of age or otherwise unable to sign, by the Patient's Legal Guardian or Power of Attorney		
Patient Name - Last	First	Middle
Relationship to Customer ❍ Self ❍ Other:		
Work Phone	Home/Cell Phone	Home Email
Physician Name and Practice Name. *Attach additional sheets if more than one attending physician.*		
Full Address		
Phone	Fax	
By signing this request, I authorize my health care provider(s) referenced above, or any other health care provider(s) who has any information regarding my condition(s) related to this request, to release my medical information pertaining to my medical emergency certificate request to DTE Energy to assist with the review and processing of my request. I certify that the patient lives at the address listed above and that all information provided is accurate.		
Patient / Legal Guardian / Power of Attorney Signature	**Date**	

iHEAL MEDICAL EMERGENCY HOLD REQUEST

Section 3: To be completed by the physician or Public Health Official

Please identify the medical emergency by completing one of the following boxes:

❍ **Critical Care Patient** – A patient that requires home medical equipment or a life support system* and that an interruption of service would be immediately life-threatening.

The following medical equipment or life support system(s) is/are used by the patient:

Device: ______________________________ ❍ Electricity ❍ Natural Gas

Device: ______________________________ ❍ Electricity ❍ Natural Gas

Device: ______________________________ ❍ Electricity ❍ Natural Gas

**This device must run on electricity or natural gas supplied by DTE Energy. Some of the equipment types that are considered medical equipment or a life support system: Aerosol tent, Apnea monitors, Compressor / Concentrator, Electronic nerve stimulator, Electrostatic nebulizer, Feeding or infusion (pump) machine, Heart monitor, Home dialysis treatment, Intermittent positive pressure breathing (IPPB) machine, Iron lung, Motorized wheelchairs, Oxygen concentrators, Pressure breathing treatment, Pressure pads and pumps, Respirator, Suction machine, Ultrasonic nebulizer and Ventilator.*

Note: CPAP & BPAP machines for adult sleep apnea do not normally qualify

❍ **Medical Emergency Patient** – A patient that has an existing condition that will be aggravated by the lack of utility service.

The patient has the following medical emergency condition(s) that will be aggravated by the loss of electricity and/or natural gas service:

Condition: ______________________________ ❍ Electricity ❍ Natural Gas

Condition: ______________________________ ❍ Electricity ❍ Natural Gas

Check One ❍ Physician ❍ Public Health Official

Name – Last	First	Middle

Professional License Number										

Licensing State

By signing below you are certifying the above information is true.

Physician's/Public Health Official's Signature	Date
Job Title if Non-Physician	Telephone Number ( )
Physician's/ Public Health Official's Full Address	Type of Medical Practice

Completed forms and valid identification must be submitted to **THAW** using one of the following options:

In-Person: Mercy Primary Care Center
at the Samaritan Center
5555 Conner St, Suite 2691
Detroit, MI 48226

In-Person or Mail: The Heat and Warmth Fund
535 Griswold, Suite 200
Detroit, MI 48226