

## Application for LEAP Emergency Financial Assistance

Agency Name: \_\_\_\_\_

***The information collected here is for our internal use only. All information collected is considered confidential and will not be discussed with anyone outside our agency and LEAP Emergency Financial Assistance without your permission.***

### 1. Applicant Information

Date of Application: \_\_\_\_\_ Date of Follow-Up Interview: \_\_\_\_\_

Name of Applicant: \_\_\_\_\_ Client #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Name of Co-Applicant (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address Unit/Suite City Postal Code

Phone #: (H) \_\_\_\_\_ (W) \_\_\_\_\_ Other Contact #: \_\_\_\_\_

Referral from: \_\_\_\_\_

Has the client received a LEAP grant before? Yes:  When: \_\_\_\_\_ No:

### 2. Household Information

	Name	Relationship to Applicant	Date of Birth (day/month/year)	Gender
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____
4)	_____	_____	_____	_____
5)	_____	_____	_____	_____
6)	_____	_____	_____	_____
7)	_____	_____	_____	_____

### 3. Housing Information

Do you own?  Live in social housing?  Private rental?

Dwelling type:  Detached House  Semi Detached House  Duplex

Row House  High rise (5 storeys or more)  Low rise (under 5 storeys)

Moveable Dwelling  Other (please specify): \_\_\_\_\_

Primary Heating Source: Electricity  Natural Gas  Other Fuel Type

Monthly Rent: \$ \_\_\_\_\_ Mortgage: \$ \_\_\_\_\_

**4. Income Information**

**Employment Income** Verified through documentation?

Applicant: \$ \_\_\_\_\_   
Other household member(s): \$ \_\_\_\_\_

**Support Payments**

Employment Insurance \$ \_\_\_\_\_   
Ontario Works \$ \_\_\_\_\_   
Ontario Disability Support Program (ODSP) \$ \_\_\_\_\_   
Canada Pension Plan \$ \_\_\_\_\_   
Workplace Safety and Insurance Board (WSIB) \$ \_\_\_\_\_   
Other (please specify): \_\_\_\_\_ \$ \_\_\_\_\_

**Other household member's other income:** \$ \_\_\_\_\_

**Other (monthly):** \$ \_\_\_\_\_

**Total Monthly Income:** \$ \_\_\_\_\_ **Total Annual Income:** \$ \_\_\_\_\_

If you are on social assistance, have you accessed the Shelter Fund or Community Homelessness Prevention Initiative in the last 24 months? Yes:  No:

Social Assistance Worker's Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**5. Arrears & Service Provider Information**

Name of Service Provider: \_\_\_\_\_

Check service provider type that applies:  Utility  Unit Sub-Meter Provider

If Unit Sub-Meter Provider, name of Utility that serves applicant's building:  
\_\_\_\_\_

Account Number: \_\_\_\_\_  
Amount of arrears: \$ \_\_\_\_\_ Verified by service provider?

Do the arrears include a security deposit, reconnection fee, equipment rental and/or financing charges?  
Yes:  Amount: \$ \_\_\_\_\_ No:

Reason(s) for current arrears & request for assistance:

- High heating costs
- Job loss
- Illness
- Pending EI

- Marital breakdown
- Unusually High Bill
- Unexpected Expenses
- Child Tax Benefit Issues
- Child Support Issues
- Other (*provide details*): \_\_\_\_\_

Grant requested: \$ \_\_\_\_\_

Has the applicant spoken to Service Provider about arrears? Yes  No

If yes, what was the result of the discussion(s)? (*provide details*): \_\_\_\_\_

Details on Disconnection notice (*if applicable*): \_\_\_\_\_

Scheduled date of disconnection (*if applicable*): \_\_\_\_\_

Last payments made on the account: Date: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

Date of last contact with Service Provider: \_\_\_\_\_

Payment Arrangements (*provide details*): \_\_\_\_\_

**6. Service Agreement**

*I, the undersigned, affirm the information provided is true. I acknowledge that should any information provided be found not to be true, I will not be eligible for LEAP Emergency Financial Assistance. I understand that payment of funds is not guaranteed, even if preliminary approval is granted. If my bill is in excess of the LEAP Emergency Financial Assistance grants, I agree to make a payment arrangement with my service provider for the balance. I understand that if I fail to make payments, which I have agreed to pay directly to my service provider, my utility service may be disconnected, and I may not be eligible for future LEAP Emergency Financial Assistance. I have read, understood and agree to these conditions and requirements.*

\_\_\_\_\_  
Applicant signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent name (please print)

\_\_\_\_\_  
Agent's signature

- TO BE COMPLETED BY AGENCY -

**Recommendation**

Grant: Yes  Amount: \$ \_\_\_\_\_ Criteria have been met

No  If no, please give rationale (*check all that apply*):

- |   |   |
|---|---|
| <input type="checkbox"/> Does not meet income criteria  | <input type="checkbox"/> Did not provide required documents   |
| <input type="checkbox"/> Cannot maintain housing  | <input type="checkbox"/> No attempt at recent payment         |
| <input type="checkbox"/> Does not live at address of arrears                                    | <input type="checkbox"/> Not a customer of a service provider |
| <input type="checkbox"/> Already accessed funds during year                                     | <input type="checkbox"/> Insufficient program funds remaining |
| <input type="checkbox"/> Arrears too large for grant amount to allow customer to stay connected |   |
| <input type="checkbox"/> Other ( <i>please specify</i> ): _____                                 |   |

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

**Low-Income Energy Assistance Program (LEAP)  
Emergency Financial Assistance  
Consent to Disclose Information**

**Personal Information:**

**Name:** \_\_\_\_\_

(First, Middle Initial, Last)

**Name of Service Provider:** \_\_\_\_\_

**Service Provider Account Number:** \_\_\_\_\_

**Residential Address:** \_\_\_\_\_

(Street Address, Unit Number, City, Postal Code)

**Consent:**

I grant my consent to \_\_\_[Agency]\_\_\_ to obtain information about my account with my Service Provider (including the status of my account balance) for the purpose of determining my eligibility for LEAP Emergency Financial Assistance. I also grant my consent to my Service Provider to use and disclose my personal information for these purposes.

\_\_\_\_\_  
*Signature of person giving consent*

\_\_\_\_\_  
*Date*

By completing this form, you may be contacted by your Service Provider about participation in energy conservation programs. If you do not wish to be contacted about such programs, you can opt-out by initialing here: \_\_\_\_\_

Please return completed form  
to:

at

\_\_\_\_\_  
*Agency Name*

\_\_\_\_\_  
*Fax #*