

# APPLICATION FOR STATE EMERGENCY RELIEF

Michigan Department of Human Services

Case Name:  
Case Number:  
Date:  
DHS Office:  
Specialist:  
Phone:  
Fax:  
Specialist ID:  
Client ID:

I hereby make application for the State Emergency Relief (SER) Program. I understand that the following information will be used in the determination of my eligibility for SER. If this application is for burial services, I understand that it must be received by the DHS office in my area no later than 10 calendar days after the burial, cremation or donation takes place.

**ADDRESS INFORMATION**

1. Check where you live:  House/apartment/mobile home  Homeless  Other \_\_\_\_\_
2. **Address where you live** (number, street, rural route, apartment/lot number)

\_\_\_\_\_  
 City State Zip code County

3. **Mailing Address** (if different from above, or PO box)

\_\_\_\_\_  
 City State Zip code County

4. Home phone Cell phone Work phone

\_\_\_\_\_  
 Phone number where we can leave a message Whose phone number is it? (name/relationship)

\_\_\_\_\_  
 TDD/Other number Email address

**Check the service(s) you are requesting and the amount needed to resolve the emergency – PROVIDE PROOF**

1. Energy/Non-Energy Services

1a.  Rent \$ \_\_\_\_\_

1b.  Security Deposit \$ \_\_\_\_\_

1c.  Moving Expense \$ \_\_\_\_\_

1d.  Heat \$ \_\_\_\_\_ Deliverable fuel % \_\_\_\_\_

1e.  Electricity \$ \_\_\_\_\_

1f.  Furnace Repair \$ \_\_\_\_\_

1g.  Water/sewer or cooking gas \$ \_\_\_\_\_

1h.  Mortgage \$ \_\_\_\_\_

1i.  Taxes \$ \_\_\_\_\_

1j.  Insurance \$ \_\_\_\_\_

1k.  Home Repairs \$ \_\_\_\_\_

1l.  Food \$ \_\_\_\_\_

What Needs Repair? \_\_\_\_\_

2.  Burial services \$ \_\_\_\_\_

3.  Migrant hospitalization \$ \_\_\_\_\_

**HOUSEHOLD INFORMATION**

List below all members of your household, including adults and children temporarily absent due to illness or employment. Be sure to include the date of birth and citizenship status for each member. A person is considered a member of your household if they sleep and keep their belongings in your home. Ask for more pages if you need to include additional members.

Name	Social Security number	Date of birth	Citizen?	Does this person claim they have no responsibility for household emergencies?
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Case Name	Case Number	Specialist
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**ASSETS**

1. Does anyone in your household have any vehicles?  
 **No**  
 **Yes** → Check all vehicles that apply and complete the information below. **ATTACH CURRENT PROOF of value/amount owed.**

Car       Truck       Boat       Camper/trailer       Motorcycle       RV       Other vehicle

Owner(s) (As shown on vehicle title or registration)	Year	Make/Model	Value	Amount Owed
			\$	\$
			\$	\$

2. Does anyone in your household have any assets (include assets held jointly)?  
 **No**  
 **Yes** → Check all types of assets that your household has and complete the following information below.  
**ATTACH CURRENT PROOF of amount/value.**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Cash  | <input type="checkbox"/> Money market accounts                 | <input type="checkbox"/> Certificate of deposit                  |
| <input type="checkbox"/> Checking account  | <input type="checkbox"/> Christmas club accounts               | <input type="checkbox"/> IRA, KEOUGH, 401K or                    |
| <input type="checkbox"/> Savings account   | <input type="checkbox"/> Savings bonds, stocks or mutual funds | Deferred Compensation account(s)                                 |
| <input type="checkbox"/> Credit union account  | <input type="checkbox"/> Land contract, mortgage or other note | <input type="checkbox"/> Real estate                             |
| <input type="checkbox"/> Life estate   | <input type="checkbox"/> Payable to household member           | <input type="checkbox"/> Tools and equipment, livestock or crops |
| <input type="checkbox"/> Life insurance  | <input type="checkbox"/> Burial plot(s), casket, etc.          |  |
| <input type="checkbox"/> Burial trust/funeral contract(s)                              | <input type="checkbox"/> Patient trust fund                    |  |
| <input type="checkbox"/> Other (mineral/water rights, government payments, etc.) _____ |  |  |

Owner(s) of asset(s)	Type(s) of asset(s)	Balance amount or value (If none, enter none)	Name and address (bank, insurance company, etc.)	Account or policy number
		\$		
		\$		

3. Has anyone in your household:

- Closed any accounts, removed or added a name to any asset or sold/given away property, land, stocks, bonds, vehicles, savings, cash, etc. in the past 90 days?  
 No  
 Yes →

Who	What	Date	How much?
_____	_____	_____	_____

- Filed a lawsuit which may provide money or property in the next 30 days?  
 No  
 Yes →

Who	What	Date	How much?
_____	_____	_____	_____

Case Name	Case Number	Specialist
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**EMPLOYMENT INCOME** – Is anyone in your household employed?  **No**  **Yes** → If yes, it is necessary that we project income for the next 30 days. List all earnings that anyone who resides in your household expects to receive in the next 30 days. **ATTACH CURRENT PROOF.**

Employee's name (First and last name)	Employer's name	Employer's address and phone number	Start date	If new job, date of first paycheck	✓ How often paid:					Day of week pay is received (i.e. Mon, Tues, Wed., etc.)	Gross earnings (before taxes)	Average number of hours expected to work per:
					Weekly	Every other week	Twice a month	Monthly	Other			
1					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> SU	<input type="checkbox"/> Week <input type="checkbox"/> Every other week <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Irregular <input type="checkbox"/> Contractual	<input type="checkbox"/> Week <input type="checkbox"/> Pay period
2					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> SU	<input type="checkbox"/> Week <input type="checkbox"/> Every other week <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Irregular <input type="checkbox"/> Contractual	<input type="checkbox"/> Week <input type="checkbox"/> Pay period

**SELF EMPLOYMENT INCOME** – Is anyone in your household self-employed?  **No**  **Yes** → If yes, **ATTACH CURRENT PROOF.**  
(Attach additional sheet if needed.)

Self-employed person(s)	Type of work or business (For example: child care provider, personal care provider, etc.)	Business name and address	Gross monthly income (amount before any expenses)	Average number of hours expected to work per week
			\$ _____	
			\$ _____	

**UNEARNED INCOME** – Does anyone in your household receive any unearned income?  **No**  **Yes** → If yes, it is necessary that we project unearned income for the next 30 days. List all unearned income that anyone who resides in your household expects to receive in the next 30 days. **ATTACH CURRENT PROOF.**

↓ Check all boxes that apply and complete the following:

<input type="checkbox"/> Social Security benefits	<input type="checkbox"/> Supplemental Security Income (SSI)	<input type="checkbox"/> Disability benefits
<input type="checkbox"/> Pension/retirement benefits	<input type="checkbox"/> Worker's compensation	<input type="checkbox"/> Unemployment compensation
<input type="checkbox"/> Veteran's benefits	<input type="checkbox"/> Money from friends or relatives, etc.	<input type="checkbox"/> Rental income
<input type="checkbox"/> Military allotments	<input type="checkbox"/> Child support	<input type="checkbox"/> Name of tenant: _____
<input type="checkbox"/> Land contract, mortgage or other payment payable to a household member		
<input type="checkbox"/> Tribal payments (LIHEAP/energy assistance, tribal GA, land claims, casino/gambling profit sharing, per capita, etc.)		
<input type="checkbox"/> Other _____		

Person(s) receiving/ expecting money	Income source/ type	How often received	Day of week received (i.e. Mon, Tues, etc.)	Date received	Amount received	Expected to continue	Date expected if not yet received
					\$ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	
					\$ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	

Case Name	Case Number	Specialist
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**INCOME EXPENSES**

3. Does anyone in your household pay any of the following expenses?

**No**

**Yes** → Check all boxes that apply and complete the following. **ATTACH PROOF**

<input type="checkbox"/> Health insurance premium \$ _____	Paid how often? _____	Covers what time period (1mo., 3 mos., etc.) _____
<input type="checkbox"/> Court ordered child support (amount paid per month) \$ _____	Actual child care costs paid by the employed person, not DHS \$ _____	
<input type="checkbox"/> Unusual employment related expenses \$ _____ Explain _____		

**HOME HEATING CREDIT**

Did you receive a Home Heating Credit in the last six (6) months?

**No**

**Yes** → If yes, amount \$ \_\_\_\_\_ Month received \_\_\_\_\_

**CURRENT SHELTER/HEAT/UTILITY EXPENSES – ATTACH CURRENT PROOF.**

Check all expenses you are required to pay		How do you heat your home? <b>PLEASE SPECIFY</b> (natural gas, electricity, propane (LP gas), wood, fuel oil, coal, etc.)	Name and address of landlord, mortgage company, and/or energy company	Account number	Is there a common/shared meter?	Name and address on the bill
<input type="checkbox"/> Rent	\$ _____ per mo.					
<input type="checkbox"/> Mortgage	\$ _____ per mo.					
<input type="checkbox"/> Tax	\$ _____ per mo.					
<input type="checkbox"/> Home insurance	\$ _____ per mo.					
<input type="checkbox"/> Heat					<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Electricity					<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Water/sewer					<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Cooking fuel					<input type="checkbox"/> Yes <input type="checkbox"/> No	

**PRIOR HOUSEHOLD SIZE AND INCOME**

1. Please indicate the number of household members and total household income for the last six (6) months. **DO NOT** include the current month. Complete the table below.

Month						
# in household						
Total monthly income	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

**PRIOR EXPENSES**

2. Were you responsible for paying shelter/heat/electric/utility bills for any of the last six (6) months? **DO NOT** include the current month.

**No**  **Yes** → If yes, enter the months and the amount you paid. **ATTACH PROOF**

Month						
Shelter	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
Heat	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
Electric	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
Utilities	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

Case Name	Case Number	Specialist
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**BURIALS: If you are applying for burial services, please complete this section. ATTACH PROOF.**

Name of deceased	Date of death	Date of burial/cremation
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Does the deceased own their home? <input type="checkbox"/> No <input type="checkbox"/> Yes → If Yes, enter current value: \$	Address of the home
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Is there a co-owner? <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes →	Name and address of co-owner
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Does the deceased have any bank or credit union accounts: <input type="checkbox"/> No <input type="checkbox"/> Yes → Balance available on the date of death: \$
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Name of bank/credit union	Address:
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Does the deceased own any vehicles? <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes →	List make, model and value of each vehicle.
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Indicate any death benefits applied for or expected to be received and the amount.					
<input type="checkbox"/> Accident/automobile insurance \$ _____	<input type="checkbox"/> Pre-paid funeral agreements \$ _____	<input type="checkbox"/> Life insurance \$ _____			
<input type="checkbox"/> Labor union benefits \$ _____	<input type="checkbox"/> Social Security death benefits \$ _____	<input type="checkbox"/> Soldier's and sailor's fund \$ _____			
<input type="checkbox"/> Veteran's death benefit \$ _____	<input type="checkbox"/> Community assistance fund/fraternal organizations \$ _____				
<input type="checkbox"/> Other benefit (specify source) _____	\$ _____				

Name of funeral home handling the burial/cremation:	Address:	Phone #:
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Did you sign a Statement of Funeral Goods and Services with the funeral home? <input type="checkbox"/> No <input type="checkbox"/> Yes	What is the total cost of the burial/cremation? \$	Is there a memorial service? <input type="checkbox"/> No <input type="checkbox"/> Yes
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Is this a cremation? <input type="checkbox"/> No <input type="checkbox"/> Yes	Is there a contribution from family and/or friends? <input type="checkbox"/> No <input type="checkbox"/> Yes → Amount \$	Was the deceased a veteran? <input type="checkbox"/> No <input type="checkbox"/> Yes
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Place of burial:	What is your legal relationship to the deceased?
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**SIGNATURE REQUIREMENT – Please sign below. Otherwise, this application will be incomplete.**

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

I authorize the department 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 by phone, fax, email or their computer Web site all available information about my account.

**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, UNLESS THE APPLICATION IS FOR A DECEASED PERSON. TO THE BEST OF MY KNOWLEDGE, THE FACTS ARE TRUE AND COMPLETE.**

Signature of applicant or authorized representative	Date	Signature of spouse	Date
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Current address	Signature of DHS specialist	Date
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Current phone number	Identification of applicant or authorized representative
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**HEARINGS:**

If you believe any action of the department is incorrect, or if the decision to approve or deny your application is not made within 10 (ten) days of the application date, you have the right to a hearing. A request for a hearing must be in writing, signed by you or your authorized representative, and received by the Department of Human Services within 90 days following the date of this form. Hearing requests should be sent to your local DHS office in your area. You are entitled to representation by an attorney or other person of your choice. However, the department does not pay for any legal expenses.

Notes:
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AUTHORITY: Act 280, P.A. 1939, as amended (sections 400.6, 400.14, 400.24, 400.68 MCL); 45 CFR 283, 120(b); Low Income Home Energy Assistance Act of 1981, as amended; MCL 400.10; Administrative Codes Rules 400.7001-400.7049	Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.
COMPLETION: Required	PENALTY: Denial of SER.