Potential Cooling Assistance Client:

Red River Valley Community Action is in the process of accepting applications for the Residential Cooling Program in the Northeast section of North Dakota, which includes the counties of Grand Forks, Nelson, Pembina, and Walsh.

Funding is limited and eligibility of each applicant will be based on the following criteria:

1. You **must** meet income and asset guidelines of the LIHEAP Heating Assistance Program and provide a copy of the LIHEAP Heating Assistance Data Sheet which can be obtained from County Social Services.
2. Clients who did not apply for heating assistance because they live in subsidized housing, may apply for a cooling device. The County Social Services worker processes a LIHEAP Heating Assistance application to determine income and asset eligibility and send a free-form letter to RRVCA.

This information can be faxed to 701-746-0406 or mailed to RRVCA, 1013 North 5th Street, Grand Forks, ND 58203 Attn: Kathie or Kathryn.

3. If you are under 60 years of age, #4 on the application must be completed and signed by your physician, a public health nurse, nurse practitioner, or physician's assistant. The medical provider must identify the medical condition that causes a need for cooling. If you are 60 or older, disregard #4 on the application as a medical provider's signature is not required.

You will be prioritized for assistance according to income and the immediacy of need.

If you have any questions regarding this program or the application, please contact our office at 701-746-5431 or toll free at 800-450-1823.

Low-Income Residential Cooling Program
Certification of Medical Need for Cooling Assistance

Red River Valley Community Action Agency
1013 N [illegible] Street
Grand Forks ND 582[illegible]
([illegible]) [illegible]46-5431 or Toll Free 1-800-[illegible]

Client #

☐ OWN ☐ RENT

Assistance under the Low Income Residential Cooling Program can only be granted to households whose income and assets are within the guidelines of the Heating Assistance component, as described in Section H-1 and H-2 of the North Dakota State LIHEAP Plan of Operation and can provide documentation of an existing medical need for a cooled living space.

To certify a medical need for cooling, an applicant must provide the following:

1. Head of Household

Name	
Address	
Telephone	Social Security Number

2. Person or persons for whom the medical need is being certified

Name		
Date of Birth	Relationship (to head of household)	Social Security Number

3. Release of Information

As an applicant for assistance under the Low Income Residential Cooling Program, I authorize persons having custody or knowledge of information relating to me to furnish requested information, to include but not limited to medical and other confidential information, to the North Dakota State Department of Health and Consolidated Laboratories, the Community Action Program, or the authorized agents of either, for the purpose of determining eligibility for cooling assistance.

Signature of Applicant Person for whom medical need is being certified. Signature of guardian or parent if applicant under 18 years of age.	Date

4. Certification by medical doctor, public health nurse, nurse practitioner, or physician's assistant

Medical condition(s)/diagnosis(es) requiring a cooled living space:

Acceptable conditions include – confinement to bed, needing assistance of visiting nurses, mental problems, seizure disorder, heart or vascular problems, pulmonary condition, kidney disease, prior heatstroke, or individuals on a fluid-restrictive diet or taking medications that interfere with the body heat regulatory system, such as neuroleptics (e.g. antipsycotics and major tranquilizers), or medications with anticholinergic effects (e.g. tricyclic antidepressants, antihistamines, some antiparkinsonian agents, and some over-the-counter sleep medications). Other medical reasons may be considered, but require an explanation as to why the individual is at increased risk of heat-related illness. An assertion that cooling is required because of "advanced age or disability" without other contributing factors is not sufficient to establish medical need.

5. Signature of medical official certifying medical need for cooling space

Name (Print or Type)	Title
Signature	Date
Clinic Name	Address

LIHEAP Cooling Program Landlord Release Form

I (landlord) ____ agree to allow

(tenant) ____

the installation of an air conditioner supplied by Red River Valley Community Action in

Location: (Unit #) ____

(Address) ____

(City/State/Zip) ____________________________________

This agreement acknowledges that the tenant is the rightful owner of the air conditioner and as the owner, has the right to take the air conditioner with them when they move out of the above stated residence.

Signed:

Tenant ____ Date ______________________

Landlord ______________________________________ Date ______________________

Red River Valley Community Action
1013 N 5th St., Grand Forks, ND 58203
(701) 746-5431 - (701) 746-0406 Fax - 1-800-450-1823 Toll Free

Date:

* Items are Required to be Answered

Services: Check all that apply

- ☐ Commodities
- ☐ Energy Share
- ☐ Emergency Services
- ☐ Food Pantry
- ☐ Home Rehab
- ☐ Rent Assistance
- ☐ Security Deposit
- ☐ Self Reliance
- ☐ Shelter
- ☐ Veterans Services
- ☐ Weatherization
- ☐ Other

Personal Information for Head of Household (HOH)*

First Name ______ MI ______ Last Name ______

Address ______

City ______ State ______ Zip Code ______ County ______

Date of Birth* ______

Social Security #* ______

Gender *
- ☐ Male
- ☐ Female
- ☐ Other:

Disabled*
- ☐ Yes
- ☐ No

Ethnicity*
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Telephone*
- Home ______
- Cell ______

Race*
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ Biracial/Multi-racial
- ☐ Black or African American
- ☐ White
- ☐ Other

Education*
- ☐ 0-8
- ☐ 9-12 (non-grad)
- ☐ GED
- ☐ High School Grad
- ☐ 12+ Grad
- ☐ College Degree

Health Insurance*
- ☐ None
- ☐ Private
- ☐ VA
- ☐ Medicare
- ☐ Medicaid
- ☐ Other

Food Stamps
- ☐ Yes
- ☐ No

If Yes - Amount* ______

Veteran*
- ☐ Yes
- ☐ No

Income Sources*

		Additional Income	Additional Income
Name			
Source(Wages, SSI, etc.)			
Pay Per Hour			
Hours per Week			
Total Monthly Income			

(Sources of income could be Employment, Unemployment, Social Security, SSI/SSDI, Child Support, TANF, Pension)

Household Type - Required*

- ☐ Female Single Parent
- ☐ Male Single Parent
- ☐ Two Parent Household
- ☐ Two Adults NO Children
- ☐ Single
- ☐ Other:

 # in Household ______

Marital Status

- ☐ Single
- ☐ Divorced
- ☐ Widowed
- ☐ Married
- ☐ Separated
- ☐ Domestic Partnership

Housing Status*

- ☐ Own
- ☐ Renter
- ☐ Homeless

Fuel Assistance (LIHEAP)

- ☐ Yes
- ☐ No

Rent/House Payment

Amount ______

Housing Assistance
- ☐ Yes
- ☐ No

Years at Residence ______

Housing Type

- ☐ House
- ☐ Apartment
- ☐ Duplex
- ☐ Mobile Home

Energy Source:

- ☐ Oil
- ☐ Natural Gas
- ☐ Propane
- ☐ Electric
- ☐ Other

Signature

Date:

Email Address:

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment basis of race, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation or all or part of the individuals income is derived from any public assistance program or protected genetic information in employment or activity conducted or funded by the department.

If you wish to file a civil rights program complaint of discrimination, complete the USDA Program Discrimination form at http://www.ascr.usda.gov/complaint filing cust.html, or at any USDA office or call 1-866-632-9992 to request the form. You may also write a letter containing all of the information requested by mail at U.S. Deparment of Agriculture, Director, Office of Adjudication, 1400 Independence Ave SW, Washington, DC 20250-9410; by FAX 202-690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 1-800-877-8339 or 1-800-845-6136 (Spanish). USDA is an Equal Opportunity

Additional Household Members - PLEASE PRINT

Name			Name
Date of Birth			Date of Birth
Social Security Number			Social Security Number
Age			Age
Relationship to HOH			Relationship to HOH
Gender			Gender
Disabled - Yes or No			Disabled - Yes or No
Race			Race
Enthnicity			Enthnicity
Education			Education
Health Insurance - Type			Health Insurance - Type
Veteran - Yes or No			Veteran - Yes or No

Name			**Name**
Date of Birth			Date of Birth
Social Security Number			Social Security Number
Age			Age
Relationship to HOH			Relationship to HOH
Gender			Gender
Disabled - Yes or No			Disabled - Yes or No
Race			Race
Enthnicity			Enthnicity
Education			Education
Health Insurance - Type			Health Insurance - Type
Veteran - Yes or No			Veteran - Yes or No

Name			**Name**
Date of Birth			Date of Birth
Social Security Number			Social Security Number
Age			Age
Relationship to HOH			Relationship to HOH
Gender			Gender
Disabled - Yes or No			Disabled - Yes or No
Race			Race
Enthnicity			Enthnicity
Education			Education
Health Insurance - Type			Health Insurance - Type
Veteran - Yes or No			Veteran - Yes or No