EMERGENCY UTILITY PAYMENT PROGRAM

Request Form

SUBMIT TO:

Contra Costa Public Health
597 Center Avenue, Suite 200
Martinez, CA 94553
Phone: 925-313-6771
Fax: 925-313-6798

****ATTACH BILL****

Medical Case Manager: Fred Smith _____ **Date:** _____

Client Name: _____**CARE ID#**_____

Category:

Name of Utility (PG&E, Telephone company, etc.)	
Date : _____ Amount of Request:	Name on Account: _____ Account Number:
Check Payable to: _____ PG&E: 15 - day ☐ 48 - hour ☐	Send Check to: Name:_____ Address: _____ City & Zip:_____

Charges for "bundled" phone bills must be unbundled.

Client Cap: Individual ($300) ☐ **Family ($450)** ☐

Quick Check: Medical Case manager **has on file** and has verified: HIV Status ☐

Income $ **FPL** **(Individual** ☐ **or calculated for family**: ☐)

Last Medical Visit Date of last utility payment access Recent assessment ☐

Other resources checked: HEAP? ☐ REACH? ☐ CARE? ☐ Lifeline? ☐

Payment plan developed with utility Y ☐ N ☐ If no why

If client is ineligible for HEAP and/or REACH programs, state why:

Office Use Only

Date Received: _____ approved by _____ Cost Center _____

ARIES check: HIV status ☐ financial updated ☐ Insurance ☐

Last MD visit_____Share/No Share status_____ cap to date_____

Recent assessment ☐ Care Plan ☐