Authorization for Release of General and/or Confidential Information For FPL Payment Assistance Qualification (*specific to FPL Care To Share Program®*)

(Revised Oct 12, 2018)

Note: The Applicant must sign this form in order for the agency to use the Florida Power & Light (FPL) ASSIST process in qualifying the FPL account for payment assistance. Refusal to sign this form may lead to disqualification. The Applicant may appeal this requirement by speaking to the agency Director/Manager, as the agency deems appropriate. The agency Director/Manager may opt to contact FPL to discuss any confidentiality concerns the Applicant may have regarding the application/qualification process.

FPL ACCOUNT HOLDER (CUSTOMER NAME): _____

SERVICE ADDRESS FOR FPL (INCL. CITY/ST/ZIP): _____

FPL ACCOUNT NUMBER: _ _ _ _ _ - _ _ _ _ _ **PHONE FOR FPL ACCOUNT:** _____

SECTION A: APPLICANT READS AND COMPLETES THIS SECTION ONLY IF HE/SHE **IS THE ACCOUNT HOLDER**

I hereby authorize FPL and this agency to disclose pertinent information to related community agencies. I understand that the need or purpose of this disclosure is solely to facilitate the assistance qualification process.

All information is accurate to the best of my knowledge. The agency may verify information contained in the payment assistance application, including the FPL account for which I am seeking assistance. I also confirm that I have not received FPL Care To Share Program assistance in the past twelve months from the date of this application, at this or any other FPL service address.

ACCOUNT HOLDER'S SIGNATURE: _____ **DATE:** _____

SECTION B: APPLICANT READS AND COMPLETES THIS SECTION ONLY IF HE/SHE **IS NOT THE ACCOUNT HOLDER**

As applicant for payment assistance for the above-referenced FPL account, I hereby confirm that I am not the Account Holder with FPL, but I am authorized by the Account Holder to initiate this assistance application on his/her behalf. This may be confirmed at the agency's discretion, by contacting the Account Holder.

All information is accurate to the best of my knowledge. The agency may verify my personal information contained in this authorization, including the FPL bill account for which I am seeking assistance. I also confirm that I have not received FPL Care To Share Program assistance in the past twelve months from the date of this application, at this or any other FPL service address.

APPLICANT'S NAME (NOT ACCOUNT HOLDER): _____

APPLICANT'S PHONE NUMBER: _____

APPLICANT'S SIGNATURE: _____ **DATE:** _____

SECTION C: FOR AGENCY USE ONLY

Agency must maintain this form in the applicant's file and make it available to FPL upon request, for accounting and auditing purposes.

AGENCY NAME : _____ **PHONE:** _____

AGENCY CASEWORKER'S NAME (*PLEASE PRINT*): _____

AGENCY CASEWORKER'S SIGNATURE: _____ **DATE:** _____

FPL ASSIST REP NAME: _____

THIS APPLICANT SATISIFIES:

1. **ALL ELIGIBILITY CRITERIA AS OUTLINED IN THE FPL CARE TO SHARE PROGRAM GUIDELINES. CHECK HERE:** ☐
2. **THE PROGRAM'S INCOME ELIGIBILITY GUIDELINES BASED ON EITHER (CHECK ONLY ONE OF THE OPTIONS LISTED BELOW):**

☐ **150% < OF POVERTY LEVEL OR** ☐ **EXPANDED INCOME LIMIT DUE TO SPECIAL CIRCUMSTANCES/NEEDS**