AMENDMENT ONE BETWEEN
AREA AGENCY ON AGING OF CENTRAL FLORIDA INC.,
D/B/A SENIOR RESOURCE ALLIANCE
STANDARD AMENDMENT

THIS AMENDMENT, entered into between the Area Agency on Aging of Central Florida, Inc., d/b/a Senior Resource Alliance, hereinafter referred to as the "Agency" and Brevard Alzheimer's Foundation, Inc.(Contractor), hereinafter referred to as the "Contractor," and collectively referred to as the "Parties," amends Contract BAFI_EHEAP_21-23**.**

WHEREAS, the purpose of this amendment is to amend contract language and replace attachments of Contract BAFI_EHEAP_21-23.

NOW THEREFORE, in consideration of the mutual covenants and obligations set forth herein, the receipt and sufficiency of which are hereby acknowledged, the Parties agree to the following:

1. Attachment I, Section II.E.1.e., EHEAP Outreach Activity Report, is hereby replaced.
   e. EHEAP Outreach Activity Report
   Contractor shall ensure the use of outreach efforts that will inform potentially eligible households about EHEAP. The EHEAP Outreach Activity Report is due on the 10th day following the end of each quarter and shall consist of the following:
   (1) Date;
   (2) County;
   (3) Location Address;
   (4) Description of Activity; and
   (5) Name and Position of Staff.
2. Attachment IX, Budget Summary, is hereby replaced.
3. Attachment XVII, EHEAP Application and Eligibility Worksheet, is hereby replaced..

All provisions in the contract and any attachments thereto in conflict with this Amendment shall be and are hereby changed to conform to this Amendment.

All provisions not in conflict with this Amendment are still in effect and are to be performed at the level specified in the contract.

This Amendment and all its attachments are hereby made part of the contract.

IN WITNESS WHEREOF, the Parties have caused this six (6) page Amendment to be executed by their officials as duly authorized, and agree to abide by the terms, conditions and provisions of contract BAFI_EHEAP_21-23**,** as amended. This Amendment is effective on the last date the Amendment has been duly signed by both Parties.

Brevard Alzheimer's Foundation, Inc.

SIGNED BY: DocuSigned by: Tim Timmerman 6F92CD373C704E0...

NAME: Tim Timmerman

TITLE: Executive Director

DATE: 7/6/2021

Area Agency on Aging of Central Florida, Inc., d/b/a Senior Resource Alliance

SIGNED BY: DocuSigned by: 2A7EFFD20BD74F3...

NAME: Karla Radka

TITLE: President and Chief Executive Officer

DATE: 7/6/2021

Federal Tax ID: **59-3369526**

Duns: **022239011**

ATTACHMENT IX

BUDGET SUMMARY

PSA: 7

BREVARD ALZHEIMER'S FOUNDATION, INC.

	EHEAP FUNDS	FY 2021/2023 INITIAL AWARD	FY 2021/2023 Spending Authority*
1	ADMINISTRATION	$12,471.63	$10,779.30
2	OUTREACH	$3,485.85	$3,012.85
3	CRISIS ASSISTANCE	$100,089.08	$86,513.44
4	WEATHER RELATED/SUPPLY SHORTAGE CRISIS**	$2,629.12	$2,264.60
5	GRAND TOTAL (Lines 1+2+3+4)	$118,675.68	$102,570.19

Projected minimum number of Individuals to be served Crisis Energy Assistance **

360

***Program expenditures may not exceed the spending authority as provided in the Budget Summary. As program funds are released, written notification of additional spending authority will be provided to the Contractor.**

****Eligible households may be provided with one benefit per season. The minimum number of consumers may reflect duplicated consumers if a consumer receives a benefit in both seasons.**

****Weather Related/Supply Shortage funds are a set-aside for emergency assistance. These funds must be held in this budget line item category until December 15th of the program year, for use in response to a possible disaster.**

ATTACHMENT XVII
EHEAP APPLICATION AND ELIGIBILITY WORKSHEET

Section One: Applicant (Aged 60 and older) Information			
Name: (First, M, Last)		☐ Heating Season ☐ Cooling Season	Date Stamp
Date of birth:	Age:	SSN:	
Service address:			
City:	Florida County:	ZIP Code:	Intake worker's name:
Sex: ☐ Male ☐ Female	Number of people in the household:	Phone:	Phone:
Marital Status: ☐ Married ☐ Partnered ☐ Single ☐ Separated ☐ Divorced ☐ Widowed			
Race: ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other			
Ethnicity: ☐ Hispanic/Latino ☐ Other		Primary Language: ☐ English ☐ Spanish ☐ Other	
Does client have limited ability reading, writing, speaking, or understanding the English language? ☐ Yes ☐ No			
Is the client a veteran? ☐ Yes ☐ No		Was client referred to the local Veteran's Affairs office? ☐ Yes ☐ No ☐ N/A	
Applicant's income type(s):		Applicant's monthly income amount:	

Section Two: Additional Household Members Information			
Name:		Income type(s):	
	Age:	SSN:	Monthly income amount:
Name:		Income type(s):	
	Age:	SSN:	Monthly income amount:
Name:		Income type(s):	
	Age:	SSN:	Monthly income amount:
Name:		Income type(s):	
	Age:	SSN:	Monthly income amount:
Name:		Income type(s):	
	Age:	SSN:	Monthly income amount:

Section Three: Household Characteristics
Is there a child 5 years of age or younger in the household? ☐ Yes ☐ No If Yes, select all that applies: ☐ 0-2 years old ☐ 3-5 years old
Is there an individual with a disability in the household? ☐ Yes ☐ No
Is the applicant a U.S. citizen or an alien lawfully admitted for permanent residence? ☐ Yes ☐ No
Is the applicant a homeowner? ☐ Yes ☐ No
Does applicant live in government subsidized housing, such as Section 8? ☐ Yes ☐ No If yes, provide the complex name:
If yes, does the household receive an energy subsidy? ☐ Yes ☐ No
Does applicant live in a student dormitory, adult family care home, or any kind of group living facility? ☐ Yes ☐ No If yes, provide the facility name: _____

Section Four: Heating and Cooling Information
Have you or any member of your household received energy assistance in the current season? ☐ Yes ☐ No If yes, provide the name of Agency:
Type of Assistance: ☐ Crisis ☐ Home Energy ☐ Weather-Related Date: _____
What is the primary source of home heating? (select one) ☐ Electricity ☐ Natural Gas ☐ Propane ☐ Wood/Coal ☐ Refillable Fuels

Does household use supplemental heating source? ☐ Electricity ☐ Wood/Coal ☐ N/A

Air conditioning unit type? ☐ Central A/C ☐ Window/Wall A/C ☐ Fans ☐ Other – specify (including evaporative cooler)

Section Five: Energy Crisis Explanation	Client Attestation and Signature
☐ Home cooling or heating energy source has been disconnected. *(Life-Threatening)*	The information provided on this application, is to the best of my knowledge, true and complete. I understand that priority in providingassistance will be given to those households with the lowest income and greatest need, i.e. those households in which the elderly, disabled, medically needy, or children reside. I authorize the agencyto make benefit payments directly to my energy supplier. I am awarethat after I have provided all the information requested to determine my eligibility, if I am applying for crisis assistance, the agency has 18hours to act upon my application with an eligible action. I am also aware that if I am not approved or denied within the time allowed, or not approved for the correct amount, I have a right to appeal the decision. (If you sign with an "X" two witnesses are required.)
☐ Unable to get delivery of fuel, is out of fuel, or is in danger ofbeing out of fuel for heating. *(Life-Threatening)*	
☐ Other problems with lack of cooling or heating in the home,such as needing to pay a deposit, repair of equipment, or interim emergency measure to avoid further crisis. *(Life-Threatening)*	
☐ Notified that the energy source for cooling or heating is goingto be disconnected. *(Standard)*	Client Signature:
☐ Received a notice indicating the energy source bill is delinquent or past due. *(Standard)*	
☐ Has an energy source bill for which the due date has lapsed. *(Standard)*	Date:

ALL CLIENTS SHOULD SIGN THE WAIVER, AUTHORIZING THE RELEASE OF GENERAL AND/OR CONFIDENTIAL INFORMATION FOR LIHEAP/EHEAP FEDERAL REPORTING.

*Your Social Security Number (SSN) is confidential under law. We may not collect your SSN unless we explain the reason for collecting your SSN in writing and provide the applicable statutory authority for doing so. Certain provisions of Chapter 430, Florida Statutes, read with Section 119.071(5), Florida Statutes, specifically authorize the Department of Elder Affairs (DOEA) and its designated staff/employees to collect SSNs when authorized by law or when collection of SSNs is imperative to the performance of DOEA's statutorily assigned duties. The Department is collecting your social security number as part of its responsibility to provide Emergency Home Energy Assistance.

Emergency Home Energy Assistance for the Elderly Program - Eligibility Worksheet

Section Six: Income Eligibility Determination

Annualize all household income.	Staple calculator tape here showing income calculations or write calculationsin this space.	**Poverty Guidelines effective 07/01/2020.**
1. Add all gross monthly earned and unearned income from the past 30days of all household members.		Select the annual income limit by household size: 150%
2. Add Medicare Premium ($148.50),if not included in SSA amount.		☐ 1.....$19,140 — $ 6,380
3. Add Medicare Part D, if applicable.		☐ 2.....$25,860 — $ 8,620
4. To annualize, multiply the monthlytotal by 12 months.		☐ 3.....$32,580 — $10,860
Annual Household Income $_____		☐ 4.....$39,300 — $13,100
		☐ 5.....$46,020 — $15,340
		☐ 6.....$52,740 — $17,580
		☐ 7.....$59,460 — $19,820
		☐ 8.....$66,180 — $22,060
		(Add $6,720 for each additional member of family unit with more than 8 members.)

☐ Categorically Eligible	If the total annual household income is less than 50% of the current Federal Poverty Guidelines for household size (using chart above), and no one in the household is receiving SNAP assistance, the applicant must provide a signedstatement of how basic living expenses (i.e., food, shelter and transportation) are provided for the household.

Section Seven: Vendor, Benefit, and Verification Information

Energy Vendor #1 Name:	**Other Vendor #1** Name:		Contact made with LIHEAP provider to verify previous crisis assistance. Contact Person: _____ Date of contact: _____ Has the applicant received LIHEAP crisis assistance during the current season? ☐ Yes ☐ No
Account Number:	Account/Voucher Number:	Date:	
Minimum Amount Due:_____	Amount Due:_____		
Verification and Commitment Contact Person: _____ Date:_____	☐ Blanket ☐ Portable Fan ☐ Space Heater ☐ Window A/C ☐ Repair Existing Heating or Cooling Equipment ☐ Emergency Shelter ☐ Other		If the minimum amount due is more than the past due amount, did the energy vendor verify that this amount is required? ☐ Yes ☐ No ☐ N/A
Energy Vendor #2 Name:	**Other Vendor #2** Name:		
Account Number:	Account/Voucher Number:	Date:	If the minimum amount due to resolve thecrisis is more than the maximum allowed,explain how the balance of the amount due will be paid if approved for EHEAP crisis assistance.
Minimum Amount Due:_____	Amount Due:_____		
Verification and Commitment Contact Person: _____ Date:_____	☐ Blanket ☐ Portable Fan ☐ Space Heater ☐ Window A/C ☐ Repair Existing Heating or Cooling Equipment ☐ Emergency Shelter ☐ Other		

(1) Total Energy Vendors	$	**(4) Total Other Vendors**	$	Is the name on the fuel billthat of the applicants? ☐ Yes ☐ No If no, provide name on bill:
(2) Energy Subsidy	$	**Total EHEAP Benefit Add Total Energy Vendor (4) & Total Other Vendor (4)**	$	
(3) Water, Sewer, Garbage, Fire, etc.	$			
(4) Deduct (2&3) from (1)	$			

Section Eight: Weatherization Assistance Program (WAP) Referral

If the applicant is a homeowner, has he/she received more than three LIHEAP or EHEAP benefits in the last 18 months?
☐ Yes ☐ No ☐ N/A

If the answer to the previous question is "yes", was the applicant referred to WAP? ☐ Yes ☐ No ☐ N/A

If the answer to the last question is "no", explain:_____

Section Nine: Resolution of Crisis

Resolution of the Heating/Cooling Energy Crisis occurred within 18/48 hours, by the following eligible action(s): (Select all that apply)	
☐ Approval of application	☐ EHEAP benefit prevented disconnection
☐ Commitment made to vendor	☐ EHEAP benefit restored energy already disconnected
☐ Denial of Application, pending additional information	☐ Yes, client signed waiver
☐ Denial of Application, ineligible	☐ No, client refused to sign waiver
☐ Written referral and assistance to access other community resources	
Case Worker Signature	**Approval Signature**
I have determined the eligibility of the applicant. I am not the applicant, nor am I a friend, relative, or employee of the applicant.	The application and eligibility determination must be reviewed for errors and appropriate file documentation prior to making payment. I have reviewed and approved this application for crisis assistance.
Case Worker's Name:	Supervisor/Peer's Name:
Case Worker's Signature:	Supervisor/Peer's Signature:
Date:	Date:
Agency Name:	Agency Name: