Name ____ TWP or Boro ____________________________

DOB:____________________ SSN:_______________________ How did you hear about Wx:____________________

Address ______________________________________ Rent / Own (Circle One)

______________________________________ Phone ____

______________________________________ Alt Phone ____________________________________

Email _________________________________

# of Adults_________________ # of Children________________ # of Disabled_______________

Other Household Occupants - Name/Relationship to Applicant/Gender/Age

1. ____ 5. ____

2. ____ 6. ____

3. ____ 7. ____

4. ____ 8. ____

Length of Time Living in Home: _________________________ Type of Fuel: __________________________

Does the Heater work? Yes / No Type of Heater: FHW(forced hot water/pipes) FHA(forced hot air/vents)

Comments on Heater:____

Type of House: Single Twin Duplex Row Townhouse Apartment Mobile

Has your home ever been weatherized by the Opportunity Council? Yes / No If yes, when?______________________

Roof Leaks – Yes / No Where ____

Plumbing Leaks– Yes / No Where ____

Basement – Yes / No Wet / Damp Comments____

Mold – Yes / No Where ____

Structural Damage – Yes / No Where ____

INCOME OR Automatic Eligibility - SSI / TANF – *GROSS Amounts*

Income ____ $_______________ Start Date______________________

Income ____ $_______________ Start Date______________________

Income ____ $_______________ Start Date______________________

COVID19 Screen Questions

Client Name: ____ **Date:** ____________

1. Has anyone in the household tested positive for COVID-19? If so, how long ago? *(YES / NO)*
   Comments: ____
2. Does your household contain a person who is considered to "at- risk" due to weakened immunity or an elderly person? *(YES / NO)*
   Comments: ____
3. Has anyone in your household been in contact with someone who has had a fever, cough or shortness of breath in the last two weeks? *(YES / NO)*
   Comments: ____
4. In the last month, have you been in contact with someone who was confirmed or suspected to have COVID-19? *(YES / NO)*
   Comments: ____
5. In the last month, have you traveled internationally, out of PA, or to an area with a known COVID-19 outbreak? *(YES / NO)*Look at COVID STATE OUTBREAK*
   Comments: ____
6. In the last month, have you been in close contact with anyone that has traveled internationally, out of PA, or to an area with a known COVID-19 outbreak? *(YES / NO)*Look at COVID STATE OUTBREAK*
   Comments: ____
7. Has anyone in the household been within 6 feet of a person with a lab-confirmed case of COVID-19 for at least 5 minutes, or had direct contact with their mucus or saliva, in the past 14 days? *(YES / NO)*
   Comments: ____
8. In the last **48 hrs**, have you had any of the following symptoms? *(YES / NO)*
   (Fever) (Cough) (Trouble breathing) (Shortness of breath / wheezing) (Chills) (Muscle aches) (Sore throat) (Loss of smell or taste.)
   Comments: ____

Date of Request____________________ Date Application Mailed_________________________