Authorization for Release
Of General and/or Confidential Information
For FPL Payment Assistance Qualification

(Revised May 15, 2014)

Note: The FPL <u>Account Holder</u> or <u>Applicant</u> must sign this authorization in order for the agency to utilize FPL's ASSIST process in qualifying the account for payment assistance on the referenced FPL bill account. <u>Refusal to sign this form may disqualify the applicant from participating in the FPL ASSIST payment assistance process.</u> The applicant may appeal the requirement to sign this form by requesting to speak with the agency Director/ Manager, as the agency deems appropriate. The agency Director/ Manager may opt to contact FPL to discuss any confidentiality issues on behalf of the applicant, in order to facilitate the application and/or qualification process.

FPL Account Holder (Customer Name): _____

Service Address for FPL (incl. city/st/zip): _____

FPL Account Number: _____ Phone for FPL Account: _____

Previous FPL Address: _____

<u>SECTION A: COMPLETE ONLY IF APPLICANT IS ACCOUNT HOLDER OF RECORD</u>

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 Florida Power & Light Company (FPL) account for which I am seeking assistance.

Account Holder's Signature / Date: _____

Account Holder's Alternate Phone Number: _____

- If seeking assistance from the FPL Care To Share® Program, I 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. *Please initial* _____

<u>SECTION B: COMPLETE ONLY IF APPLICANT IS NOT ACCOUNT HOLDER OF RECORD</u>

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. *Please initial* _____

This agency may verify my personal information contained in this authorization, including the FPL bill account for which I am seeking assistance *(Please print clearly).*

Applicant's Name (not account holder): _____

Applicant's Contact Phone Number: _____

Applicant's Signature / Date: _____

- If seeking assistance from the FPL Care To Share® Program, I 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. *Please initial* _____

<u> For Agency Use Only ***</u>***

This form should be maintained by the Agency in the applicant's file and made available to FPL upon request, for accounting and auditing purposes.

Agency Name / Phone: _____

FPL ASSIST Rep Name: _____

Agency Caseworker's Name (*Please Print*): _____

Agency Caseworker's Signature / Date: _____

This applicant satisfies all eligibility criteria as outlined in the FPL Care To Share Program Guidelines. ☐

This applicant satisfies income eligibility guidelines based on (<u>check one</u>): 150% < of poverty level ☐ *other crisis.* ☐