



# Project DESERVE Application

This program provides assistance to current Westar Energy customers with active service in their name. Applications may be submitted by mail to Center of Hope Inc., P.O. Box 3237, Wichita, KS 67201; by fax (316) 267-7778; or by email ProjectDeserve@centerofhopeinc.org. Online registration is available at centerofhopeinc.org. **Please see page 3 for other important information and requirements.** Assistance is determined on the basis of need, subject to the availability of funds. **If you are approved for Project Deserve funding the payment will be made directly to Westar at the end of the month.** To be eligible for this program, a member of your household must meet one of the following categories:

65 Years or Older or receives permanent disability income from SSI or SSD

**OR**

Meets the income guidelines below

*If approved, you will be assisted with the amount due on your account at the time of review, up to \$300.*

*If approved, you will be assisted with the amount due on your bill at time of review, up to \$300.*

Household information			
List <b>all</b> members of your household. Your utility bill <b>must</b> be in the name of an adult living in the household. Begin on line 1 with the account holder's name. <i>Please print</i>			
Name (First, MI, Last) (For all in household)	Social Security # (Adults only)	Sex M or F	Age
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Household Size	Net Income (in past 30 days not including food stamps)
	Monthly (past 30 days)
1	\$2,127
2	\$2,873
3	\$3,620
4	\$4,367
5	\$5,113
6	\$5,860
7	\$6,607
8	\$7,353

Applicant's telephone: \_\_\_\_\_ Applicant's email: \_\_\_\_\_

Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Please indicate with a check (✓) why you need assistance with your bill:

Not enough monthly income     
  Loss of income     
  Unusually high utility bill     
  Unusually high medical bill

Other (please explain)

Please list the following information from your utility bill:

Name of utility: \_\_\_\_\_

Account number: \_\_\_\_\_

Total bill amount: \_\_\_\_\_

Expenditures	
MONTHLY EXPENDITURES	Amount paid in the last 30 days
Rent	
Electric	
Gas	
Water	
Trash	
Cable	
Internet	
Phone	
Food	
Household	
Clothes	
Laundry	
Vehicle (payment)	
Vehicle insurance	
Gas/transportation	
Other insurance	
Credit card payments	
Pay day loan payments	
Student loan payments	
Other loan payments	
Child care	
Medical/hospital	
Tithes/contributions	
Cigarettes/alcohol	
Recreation	
Fines	
Other	
<b>TOTAL</b>	*

\* Total must agree with income



Income		
Name of person	Source	Amount received in last 30 days
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
	Food Savings	\$
Borrowed (check all that apply)	<input type="checkbox"/> Friend <input type="checkbox"/> Family <input type="checkbox"/> Payday loan	\$
	<b>Total</b>	* \$

\* Total must agree with expenditures

## IMPORTANT!

Please include **ALL** household income for all household members regardless of age or relationship.

*Source examples include: employment, SSD, SSI, SS, TAF, food stamps, unemployment, worker compensation, child support, alimony, pension, VA benefits, etc.*

Each source requires official written verification.

*Examples of verification include: paycheck stubs for most recent 30 days, letter from Social Security office (for current year), printout from DCF, printout from unemployment office, etc.*

**PLEASE DO NOT SEND ORIGINAL DOCUMENTS – ONLY SEND COPIES. ALL DOCUMENTS WILL BE DESTROYED AFTER REVIEW.**

Please read the next page (p. 3) very carefully

## **Required Verification**

To have your application for assistance considered, written verification of your situation is required. Along with this signed application, you must provide **COPIES** of the following:

- Current verification for each source of income in your household for the most recent 30 days
- Current utility bill
- One other utility bill or phone bill in your name at this address

**DO NOT include originals** as they will not be returned to you. All documents will be destroyed after review.

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## **Notification Information**

You will be notified, in writing, of our decision at the end of the month by mail. Please return completed application and verification using one of the following:

**Fax:** (316) 267-7778  
**Email:** ProjectDeserve@centerofhopeinc.org  
**Mail:** Center of Hope Inc.  
Project DESERVE  
P.O. Box 3237  
Wichita, KS 67201  
**Online:** centerofhopeinc.org

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### **READ THE FOLLOWING CAREFULLY BEFORE SIGNING**

***My signature below means that I understand and agree to all of the following:***

- ✓ I understand it is my responsibility to provide current proof of all household income, a current copy of my utility bill and another monthly bill in my name to determine my eligibility.
- ✓ **I understand I need to continue making regular payments to my energy provider and that any Project DESERVE benefits which may be received do not take the place of my responsibility to pay the vendor.**
- ✓ I understand my eligibility will be determined under the Project DESERVE guidelines.
- ✓ **I understand this assistance is available only one time in a rolling 12-month period to those who demonstrate a financial need.**
- ✓ I authorize my utility provider to release my payment history and other information to Center of Hope Inc. I also authorize Center of Hope Inc. to release application information to my energy vendor.
- ✓ **I understand applications with incomplete information or verification will not be processed and will be destroyed.**
- ✓ I certify that all information I have provided is complete and accurate.

( )

\_\_\_\_\_  
Signature of adult household member

\_\_\_\_\_  
Date

\_\_\_\_\_  
Daytime phone number