

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP) APPLICATION FOR ASSISTANCE

◆ Application is not complete without applicant signature on page 2.

Type of assistance you are applying for: (Check one)

_____ Energy Assistance _____ Crisis Assistance

Have you received assistance under the LIHEAP program since July 1, 2017 through any TN LIHEAP Agency? (circle) Yes or No

If yes, which agency provided assistance? _____

For Agency Office Use Only		
DATE	APPLICATION RECEIVED:	_____
DATE	APPLICATION COMPLETED:	_____
APPLICATION STATUS: APPROVED DENIED		

Applicant Name:	Telephone: Cell:
Current Address:	City: State: Zip:
County:	
Mailing Address (If different from Current Address):	City: State: Zip:

LIST ALL HOUSEHOLD MEMBERS (INCLUDING APPLICANT). USE ADDITIONAL PAPER IF YOU NEED MORE SPACE

NAME (must provide first and last name)	MARITAL STATUS	RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	SEX	RACE (Optional to Provide) White, Black, Hispanic, Asian/Pacific Islander, Native American, Native Alaskan, Other - define	HIGHEST GRADE OF SCHOOL COMPLETED	DOES HOUSEHOLD MEMBER RECEIVE REGULAR FINANCIAL ASSISTANCE FOR A PERMANENT DISABILITY?	HEALTH INSURANCE	INCOME	RECEIVE FOOD STAMPS, SUPPLEMENTAL SECURITY INCOME, FAMILIES FIRST CASH ASSISTANCE (INDICATE ANY RECEIVING)
Applicant Name:									Y or N	Y or N	Y or N	
Household Member:									Y or N	Y or N	Y or N	
Household Member:									Y or N	Y or N	Y or N	
Household Member:									Y or N	Y or N	Y or N	
Household Member:									Y or N	Y or N	Y or N	
Household Member:									Y or N	Y or N	Y or N	
Household Member:									Y or N	Y or N	Y or N	
Household Member:									Y or N	Y or N	Y or N	

Are any Household Members classified as a Veteran or Active Military: Yes No

FAMILY TYPE (check one)	DECLARATION OF DISABILITY (Please use additional paper if more space is needed)
Single Parent Female <input type="checkbox"/>	NAME OF HOUSEHOLD MEMBER AND PLEASE STATE PERMANENT DISABILITY:
Single Parent Male <input type="checkbox"/>	DOES HOUSEHOLD MEMBER HAVE A SIGNED MEDICAL STATEMENT THAT REQUIRES LIFE SUPPORT EQUIPMENT? (circle) YES NO
2 Parent Household <input type="checkbox"/>	NAME OF HOUSEHOLD MEMBER AND PLEASE STATE PERMANENT DISABILITY:
Single Person Female (no children) <input type="checkbox"/>	DOES HOUSEHOLD MEMBER HAVE A SIGNED MEDICAL STATEMENT THAT REQUIRES LIFE SUPPORT EQUIPMENT? (circle) YES NO
Single Person Male (no children) <input type="checkbox"/>	NAME OF HOUSEHOLD MEMBER AND PLEASE STATE PERMANENT DISABILITY:
More Than One Adult (no children) <input type="checkbox"/>	DOES HOUSEHOLD MEMBER HAVE A SIGNED MEDICAL STATEMENT THAT REQUIRES LIFE SUPPORT EQUIPMENT? (circle) YES NO

☞ NOTE 1: ASSISTANCE WILL BE DENIED DUE TO AN APPLICANT'S REFUSAL TO FURNISH ALL HOUSEHOLD MEMBERS' SOCIAL SECURITY NUMBERS AND VERIFICATION ☞

▶ NOTE 2: YOU MUST ATTACH INCOME DOCUMENTATION FOR EVERY PERSON IN HOUSEHOLD AGE 18 OR OLDER ◀

(complete both pages)

HOUSEHOLD TOTAL INCOME (Below list income information for applicant and all household members age 18 or older). Use additional paper if more space is needed.

NAME	SOURCE OF INCOME	GROSS MONTHLY INCOME	IF EMPLOYED, PROVIDE EMPLOYER'S NAME & ADDRESS

HOUSING (please check one) OWN RENT SECTION 8 PUBLIC HOUSING AUTHORITY

SOURCE(s) OF ENERGY: (Circle) **PUBLIC HOUSING/SECTION 8 TENANTS ONLY**
 Wood Electric Fuel Oil
 Coal Kerosene
 Natural Gas L.P. Gas
 Amount of Utility "Overage" \$ _____

HOME ENERGY COSTS: _____
UTILITY or ENERGY COMPANY TO RECEIVE PAYMENT:
 Utility Company Name: _____
 Utility Company Address: _____
 Phone #: _____
 Account #: _____
UTILITY or ENERGY COMPANY TO RECEIVE PAYMENT:
 Utility Company Name: _____
 Utility Company Address: _____
 Phone #: _____
 Account #: _____

IF APPLYING FOR "CRISIS" ASSISTANCE, TELL US WHY?

 Has your electric or gas been disconnected? Y or N Have you received a cut off notice? Y or N
 *If you have received a cut off notice, please attach a copy.

(PLEASE ATTACH ANNUAL ENERGY USAGE DOCUMENTATION)
 I CERTIFY THAT THE ABOVE ACCOUNT(S) IN THE NAME OF _____
 IS FOR THE USE OF MY HOUSEHOLD AND I AM RESPONSIBLE FOR ITS PAYMENTS.
 Has your home ever been served under our Weatherization Assistance Program? Y or N Are you interested in that program? Y or N

Applicant Certification:

I CERTIFY THAT ALL OF THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT. I ATTEST UNDER PENALTY OF PERJURY THAT THE APPLICANT IS EITHER A UNITED STATES CITIZEN OR A QUALIFIED ALIEN AS DEFINED BY U.S.C § 1641(b). I UNDERSTAND THAT ANYONE WHO FRAUDULENTLY COVERS UP A MATERIAL FACT OR WHO KNOWINGLY GIVES FALSE INFORMATION FOR THE RECEIPT OF LIHEAP ASSISTANCE IS LIABLE UPON CONVICTION TO A FINE OF \$10,000 OR IMPRISONMENT FOR NOT MORE THAN FIVE YEARS, OR BOTH. I AUTHORIZE THE VERIFICATION OF ANY AND ALL INFORMATION PROVIDED HEREIN TO DETERMINE MY ELIGIBILITY, AND ACKNOWLEDGE I HAVE BEEN INFORMED OF THE APPEAL PROCESS UNDER PROVISIONS OF THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM. I UNDERSTAND THAT I WILL BE NOTIFIED IN WRITING OF MY ELIGIBILITY STATUS. IDENTIFYING INFORMATION PROVIDED BY YOU FOR DETERMINATION OF YOUR ELIGIBILITY FOR LIHEAP AND FOR THE PROVISION OF SERVICES FROM THE PROGRAM WILL BE CONSIDERED CONFIDENTIAL, UNLESS OTHERWISE AUTHORIZED OR REQUIRED BY LAW, WILL NOT BE SHARED WITH ANY OTHER PERSONS OR AGENCIES EXCEPT FOR PURPOSES DIRECTLY RELATED TO THE ADMINISTRATION OF THE PROGRAM (LIHEAP). I AM THE CUSTOMER OF RECORD, THE CUSTOMER'S AUTHORIZED AGENT, OR AN AUTHORIZED THIRD PARTY FOR THE UTILITY SERVICE ACCOUNT IDENTIFIED IN THIS APPLICATION, AND I AUTHORIZE MY UTILITY SERVICE PROVIDER TO DISCLOSE MY CUSTOMER DATA AS REQUESTED BY THE LIHEAP ADMINISTERING AGENCY.
 I DO _____ OR DO NOT _____ AGREE THAT THE INFORMATION CONTAINED IN MY APPLICATION MAY BE SHARED WITH OTHER AGENCIES FROM WHICH I SEEK ADDITIONAL SERVICES.

APPLICANT SIGNATURE: _____ **DATE:** _____

No person on the basis of race, color, national origin, sex, age, disability, ancestry, status as a veteran, or any other characteristics protected by Federal, State, or Local will be excluded from participation in, or be denied benefits of, or be otherwise subjected to discrimination in the operation of the LIHEAP program.

To Be Completed By Agency Staff Only:

Number of Household Members Who Are:	
Age under 12 months	_____
Age 2 years or under	_____
Age 3-5 years	_____
Age 60-69 years	_____
Age 70 or older	_____

DATE/TIME TAKEN: _____ **TOTAL POINTS:** _____
ELIGIBLE BENEFIT LEVEL \$ _____ **% OF POVERTY** _____ **VOUCHER #:** _____

TOTAL ANNUAL GROSS INCOME ALL HOUSEHOLD MEMBERS OVER AGE 18: \$ _____

SIGNATURE OF DETERMINING AGENCY OFFICIAL: _____ **DATE CERTIFIED:** _____