

# Application for Low Income Home Energy Assistance Program (LIHEAP)

Type of assistance you are applying for:

Energy Assistance    Crisis Assistance

<i>For Agency Use Only</i>
Date Application Received:
Date Application Completed:

Have you received assistance under LIHEAP program since **October 1, 2023** through any TN LIHEAP Agency?    Yes    No

If yes, which agency provided assistance? \_\_\_\_\_

## Household Information

Primary Address	City or Town	State	Zip	County
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## Head of Household Information

First Name	Middle Initial	Last Name
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*Please complete individual information sheets for each household member, including head of household*

## Address and Contact Detail

Primary Telephone	Secondary Telephone	Email Address (optional)
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Mailing Address (if different from above)	City or Town	State	Zip	County
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## Family Detail

Family Type:    Single Individual    Female Single Parent    Male Single Parent    Adult(s) w/Child(ren)  
 Adult(s) w/out Child    Other \_\_\_\_\_

Home type:    Own    Rent    Section 8    Public Housing

Do you have a signed medical statement that states someone in your household requires life support equipment?    Yes    No

### ***Items you will need when you submit this application***

1. The application, completed in its entirety
2. Government issued identification for the head of household.
3. A household member record for each household member, including head of household
4. An income detail sheet for each household member age 18 or older
5. Social Security Number verification for every individual in the household. Assistance will be denied due to an applicant's refusal to furnish all household members social security numbers and verification.
6. Income documentation (pay stubs, etc.)
6. Annual energy consumption documentation.

**Household Member Sheet**  
**Application for LIHEAP Assistance**

Head of Household Name: \_\_\_\_\_

**Household Member Information Sheet (please use additional sheets as needed)**

Note: Assistance will be denied due to an applicant's refusal to furnish all household members' Social Security Numbers and verification

Number of members in household: \_\_\_\_\_

First Name	Middle Initial	Last Name
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Gender	Date of Birth	Social Security Number
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Relationship to household:  Head of Household  Spouse  Child  Foster Child  Grandchild  Adult Child  Parent  
 Grandparent  Other Relation  Not Related

Race (please select one):  White  Black/African American  Asian  American Indian/Alaska Native  
 Native Hawaiian/Other Pacific Islander  Multi-Racial  Other \_\_\_\_\_

Hispanic/Latino?  Yes  No

Citizenship:  U.S. Born/Naturalized  Eligible Legal Resident  Non-Eligible Legal Resident  
 Undocumented Resident

Employment, if over 18  Full Time  Part Time  Retired  Seeking Work  Unemployed  Not Available

(please select one):  Other \_\_\_\_\_  Not Applicable

Do you have medical insurance?  Yes  No

Education, if over 18:  0-8<sup>th</sup> Grade  9-12<sup>th</sup> Grade  High School Grad/GED  Non-High School Grad/GED  
 12+ Some Post Sec.  2 or 4 Yr. College Grad  4 Yr. College Grad

Disability:  None  Mental Illness  Learning  Cognitive  Visual  Speech  Hearing  Deaf  Breathing  
 Orthopedic  Other \_\_\_\_\_

Veteran or Active Military:  Yes  No

First Name	Middle Initial	Last Name
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Gender	Date of Birth	Social Security Number
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Relationship to household:  Head of Household  Spouse  Child  Foster Child  Grandchild  Adult Child  Parent  
 Grandparent  Other Relation  Not Related

Race (please select one):  White  Black/African American  Asian  American Indian/Alaska Native  
 Native Hawaiian/Other Pacific Islander  Multi-Racial  Other \_\_\_\_\_

Hispanic/Latino?  Yes  No

Citizenship:  U.S. Born/Naturalized  Eligible Legal Resident  Non-Eligible Legal Resident  
 Undocumented Resident

Employment (if over 18):  Full Time  Part Time  Retired  Seeking Work  Unemployed  Not Available  
 Other \_\_\_\_\_  Not Applicable

Do you have medical insurance?  Yes  No

Education( if over 18):  0-8<sup>th</sup> Grade  9-12<sup>th</sup> Grade  High School Grad/GED  Non-High School Grad/GED  
 12+ Some Post Sec.  2 or 4 Yr. College Grad  4 Yr. College Grad

Disability:  None  Mental Illness  Learning  Cognitive  Visual  Speech  Hearing  Deaf  Breathing  
 Orthopedic  Other \_\_\_\_\_

Veteran or Active Military:  Yes  No

**--Please attach income detail sheet(s) per household member 18 years or older--**

Application for LIHEAP Assistance

Head of Household Name: \_\_\_\_\_

Household Member Name: \_\_\_\_\_

**Income Detail Sheet (please attach one sheet per household member, more than one if necessary)**

Note: All sources of income must be reported with the exception of employment income for household members under age 18

**Income:** Is this income current?  Yes  No

Income Type:  Alimony/Child Support  Pension  Salary/Wages  Social Security  SSDI  SSI  TANF/AFDC  
 Unemployment  No income

Income Period:  Weekly  Bi-Weekly  Semi-Monthly  Monthly  Quarterly  Annually

Gross Amount per Income Period: \_\_\_\_\_

Type of Documentation Provided: \_\_\_\_\_

**Employer Detail**

Employer Name	Address	City	State	Zip	Length of Empl.

**Income:** Is this income current?  Yes  No

Income Type:  Alimony/Child Support  Pension  Salary/Wages  Social Security  SSDI  SSI  TANF/AFDC  
 Unemployment  No income

Income Period:  Weekly  Bi-Weekly  Semi-Monthly  Monthly  Quarterly  Annually

Gross Amount per Income Period: \_\_\_\_\_

Type of Documentation Provided: \_\_\_\_\_

**Employer Detail**

Employer Name	Address	City	State	Zip	Length of Empl.

**Income:** Is this income current?  Yes  No

Income Type:  Alimony/Child Support  Pension  Salary/Wages  Social Security  SSDI  SSI  TANF/AFDC  
 Unemployment  No income

Income Period:  Weekly  Bi-Weekly  Semi-Monthly  Monthly  Quarterly  Annually

Gross Amount per Income Period: \_\_\_\_\_

Type of Documentation Provided: \_\_\_\_\_

**Employer Detail**

Employer Name	Address	City	State	Zip	Length of Empl.

**--Please attach more sheets as necessary to document income--**

Note: All sources of income must be reported with the exception of employment income for household members under age 18

Application for LIHEAP Assistance

Head of Household Name: \_\_\_\_\_

LIHEAP Application Detail

Source(s) of Energy: Wood Electric Fuel Oil Coal Kerosene Natural Gas L.P. Gas

Home Energy Costs:

\*Public Housing/Section 8 Tenants Only\*

\$ \_\_\_\_\_

Amount of Utility "Overage" \$ \_\_\_\_\_

<b>Utility or Energy company to receive payment:</b>
Utility Company Name:
Utility Company Address:
Phone:
Account #:

<b>Additional Utility or Energy company:</b>
Utility Company Name:
Utility Company Address:
Phone:
Account #:

Please attach annual energy usage documentation.

I certify that the above account(s) in the name of \_\_\_\_\_

(last 4 digits of SSN) \_\_\_\_\_ relationship \_\_\_\_\_ is for the use of my household and I am responsible for its payments.

Is this account in your landlord's name? Yes No

Has your home ever been served under our Weatherization Assistance Program? Yes No

Are you interested in that program? Yes No

If applying for crisis assistance, please tell us why in the space below:

Has your electric or gas been disconnected?  Yes  No Have you received a cut off notice?  Yes  No  
*If you have received a cut off notice, please attach a copy to this application*

**Applicant Certification**

I certify that all of the information provided by me is true and correct. 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 attest under penalty of perjury that all persons applying for or receiving aid are either a United States citizen or qualified alien as defined by 8 USC § 1641(b), or eligible immigrants. 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**

Eligible benefit level \$ _____ Total annual gross income for all household members over age 18 \$ _____	
Voucher #: _____ Date/Time taken: _____	
Date/Time vendor notified: _____	Application Status: <input type="checkbox"/> Approved <input type="checkbox"/> Denied
% of poverty: _____	Total points: _____
Signature of agency reviewer official: _____	Date Certified: _____