

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, 2020** through any TN LIHEAP Agency? Yes No

If yes, which agency provided assistance? _____

Household Information

Primary Address	City or Town	State	Zip	County
-----------------	--------------	-------	-----	--------

Head of Household Information

First Name	Middle Initial	Last Name
------------	----------------	-----------

Please complete individual information sheets for each household member, including head of household

Address and Contact Detail

Primary Telephone	Secondary Telephone	Email Address (optional)
-------------------	---------------------	--------------------------

Mailing Address (if different from above)	City or Town	State	Zip	County
---	--------------	-------	-----	--------

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
------------	----------------	-----------

Gender	Date of Birth	Social Security Number
--------	---------------	------------------------

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: 0-8th Grade 9-12th 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
------------	----------------	-----------

Gender	Date of Birth	Social Security Number
--------	---------------	------------------------

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): 0-8th Grade 9-12th 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" \$ _____

Utility or Energy company to receive payment:
Utility Company Name:
Utility Company Address:
Phone:
Account #:

Additional Utility or Energy company:
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 \$ _____	<div style="border: 1px solid black; width: 100px; height: 100px;"></div>
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: _____