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

♦ **Application is not complete without applicant signature on page 2.**

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

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

_____Energy Assistance _____Crisis Assistance

Have you received assistance under the LIHEAP program since October 1, 2019 through any TN LIHEAP Agency? (circle) Yes or No

If yes, which agency provided assistance?_____

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 ☐	NAME OF HOUSEHOLD MEMBER AND PLEASE STATE PERMANENT DISABILITY:
Single Parent Male ☐	DOES HOUSEHOLD MEMBER HAVE A SIGNED MEDICAL STATEMENT THAT REQUIRES LIFE SUPPORT EQUIPMENT? (circle) YES NO
2 Parent Household ☐	NAME OF HOUSEHOLD MEMBER AND PLEASE STATE PERMANENT DISABILITY:
Single Person Female (no children) ☐	DOES HOUSEHOLD MEMBER HAVE A SIGNED MEDICAL STATEMENT THAT REQUIRES LIFE SUPPORT EQUIPMENT? (circle) YES NO
Single Person Male (no children) ☐	NAME OF HOUSEHOLD MEMBER AND PLEASE STATE PERMANENT DISABILITY:
More Than One Adult (no children) ☐	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* ☜

(complete both pages)

►**NOTE 2:** *YOU MUST ATTACH INCOME DOCUMENTATION FOR EVERY PERSON IN HOUSEHOLD AGE 18 OR OLDER* ◄

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)

Wood	**Electric**	**Fuel Oil**
Coal	**Kerosene**	
Natural Gas	**L.P. Gas**	

PUBLIC HOUSING/SECTION 8 TENANTS ONLY

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 #: _____

(PLEASE ATTACH ANNUAL ENERGY USAGE DOCUMENTATION)

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.**

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:_____***