

# 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** 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 Type (Circle One): Medicare Military Medicaid Employer Based Other

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

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 Type (Circle One): Medicare Military Medicaid Employer Based Other

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

\*Public Housing/Section 8 Tenants Only\*

If utility bill is in Section 8 or Public Housing Name, please provide documentation of overages or excess consumption amounts.

<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

<p>If applying for crisis assistance, please tell us why in the space below:</p>          <p>Has your electric or gas been disconnected?    <input type="checkbox"/> Yes    <input type="checkbox"/> No    Have you received a cut off notice?    <input type="checkbox"/> Yes    <input type="checkbox"/> No  <i>If you have received a cut off notice, please attach a copy to this application</i></p>
---

**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.*

<b>To be completed by agency staff only</b>	
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: _____

**CLIENT CERTIFICATION &KZD**

**NON-DISCRIMINATION**

No person on the basis of handicap, race, color, religion, sex, age or national origin will be excluded from participation in, or denied benefits of, or otherwise subjected to discrimination in the operation of the LIHEAP, or any CSBG Program.

**GRIEVANCE STATEMENT**

Please be aware that if an application is denied for any reason other than lack of funding the applicant has the right to appeal the decision. If you wish to file an appeal please contact your local UCHRA office or Judy Sanchez, Community Services Manager at 931-528-1127 or by mail at 580 south Jefferson Ave, Suite B, Cookeville TN 38501.

**CONFIDENTIALITY STATEMENT**

**Please be aware that your information will not be shared with other organizations or persons Without your consent. Please check on the application when asked if you do or do not agree to the Sharing of your information with the exceptions below under release of information.**

**NOTIFICATION OF CHANGE TO HOUSEHOLD**

I understand that I must inform the Upper Cumberland Human Resource Agency of any change to household information concerning income, address, energy supplier, energy supplier account number, household size and or any other changes that may determine my eligibility for agency services.

**RELEASE OF INFORMATION**

**I the undersigned do request and allow the release of my account information or any records and documents that UCHRA may need to verify my eligibility for assistance with any agency program. I agree that the agency may request information on my behalf from my Home Energy Supplier, Landlord, Mortgage company, or any other person who has knowledge or information that can verify my statements and eligibility.**

I acknowledge by my signature below that I have been provided information about the Upper Cumberland Human Resource Agency policies as described above. By signing below, I certify that I read the above policies and fully understand the agencies responsibilities and my own.

I attest under penalty of perjury that the applicant and all members listed on this application for assistance are either a United States citizen or a qualified alien as defined by U.S. C. 1641 (b).

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

**Fraud, Waste and Abuse  
Acknowledgment**

If fraud, waste or abuse of government funds is detected, an inquiry must be reported to the Tennessee Comptroller’s Office. In addition to contacting the Comptroller’s Office, local agencies must also contact THDA regarding any fraud, waste or abuse of government funds. The bulletin provided by the state with the Comptroller’s toll-free hot line number must be posted at state and local agencies. The THDA will hold annual training for state staff and local agency staff on how to detect and mitigate fraud, waste and abuse.

Assistance can be terminated for any applicant if it is found that the household has falsified any information to receive assistance or any other type of fraud, waste or abuse. Clients will be notified by mail along with an appeal form and given 10 days to respond in writing.

By signing below I am acknowledging that all the information on my LIHEAP application is true. All income is true and everyone living in the household was reported on the LIHEAP application.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date