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

→→→ Application is not complete without required documentation and signature on page 2 ←←←

Date Application Received:

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

☐ Regular Assistance ☐ Crisis Assistance

Have you received assistance under LIHEAP since October 1 through any TN Agency?

☐ Yes ☐ No If Yes, which agency? _____

Last Name:	First Name:	Middle:	Email: *Required

Physical Address:	City:	State: TN	Zip:
Mailing Address: (if different)	City:	State:	Zip:

Phone:	Alternate Phone:	County:

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

(Provide name & information for each HH member) **LAST NAME**	**FIRST NAME**	**M.I.**	**RELATION TO APPLICANT**	**SOCIAL SECURITY NUMBER**	**DATE OF BIRTH**	**SEX**	**RACE**	**Ethnicity**	**Vet or Military**	**Receive Asst for Disability**	**INCOME**	**TYPE OF INCOME**
									Y or N	Y or N	Y or N	
									Y or N	Y or N	Y or N	
									Y or N	Y or N	Y or N	
									Y or N	Y or N	Y or N	
									Y or N	Y or N	Y or N	

IF A HOUSEHOLD MEMBER IS DISABLED AND NOT RECEIVING SSI OR SSDI,
A COMPLETED VERIFICATION OF DISABILITY FORM, SIGNED BY A MEDICAL PROFESSIONAL, IS REQUIRED.

APPLYING FOR CRISIS ASSISTANCE? Let's see if you qualify

Do you have a utility disconnect, past due, disconnected, or less than $50 on pre-pay, an eviction notice due to utility overage, unpaid rent, are running or are out of fuel, your heat/airunit is not working properly? (circle one) Y or N

If Yes, documentation must be attached.In addition you must meet one of the following criteria: (Please check ALL that apply) Documentation is required for circumstances marked.

____ A household member 60 years or older in the home
____ A household member 5 years or younger in the home
____ A household member who is disabled (either receiving disability income or a verification of disability form)
____ A household member who is a veteran or active military
____ A household member requiring life support equipment
____ Household wage earner lost their job or died within the last 12 months
____ Household wage earner left the home within the last 45 days
____ Household wage earner experienced a loss of significant work hours in the past 30 days
____ Non-functioning or mal-functioning HVAC system in the home
____ Unanticipated medical or major household expense that exceeds 100% of your utility bill

▶▶▶ ASSISTANCE WILL BE DENIED DUE TO AN APPLICANT'S REFUSAL TO FURNISH ALL HOUSEHOLD MEMBERS' SOCIAL SECURITY NUMBERS AND VERIFICATION ◀◀◀

HOUSEHOLD TOTAL INCOME: List income information for applicant and all household members. Wages are only listed for household members 18 or older

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HOUSEHOLD MEMBER NAME	SOURCE OF INCOME	MONTHLY INCOME	HOW OFTEN INCOME RECEIVED

INCOME DOCUMENTATION FOR THE MOST RECENT 30 DAYS MUST BE ATTACHED FOR EVERY PERSON IN THE HOUSEHOLD
A VERIFICATION OF INCOME AND EXPENSES FORM IS REQUIRED IF THERE ARE ANY ADULT HOUSEHOLD MEMBERS CLAIMING ZERO INCOME

HOUSING: (Please check one) ☐ OWN ☐ RENT ☐ LIVE WITH OTHERS ☐ RENT w/ utilities included (Landlord/Tenant form required)

MAIN HEATING SOURCE: (Please check one): ☐ ELECTRIC ☐ NATURAL GAS ☐ PROPANE ☐ WOOD ☐ KEROSENE ☐ OTHER: _____

UTILITY COMPANY TO RECEIVE BENEFIT PAYMENT:

Utility Company Name: _____

Account Number: _____

I certify that the account is in the name of _____ is for the use of my household and I am responsible for it's payments.

***** ATTACH 12 MONTHS OF ENERGY USAGE DOCUMENTATION FROM ALL HEATING AND COOLING SOURCES*****

Has your home been served under our Weatherization Assistance Program in the last 15 years? ☐ Yes ☐ No

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 USC 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 RECORDS, 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 ☐ I DO NOT AGREE THAT THE INFORMATION CONTAINED IN MY APPLICATION MAY BY 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 characterisics, 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 LIHEAP.

SIGNATURE OF DETERMINING AGENCY OFFICIAL: _____ DATE CERTIFIED: _____

Tennessee Housing Development Agency

Verification of Income & Expenses

Applicant Name: _____ Household Number: _____
Address: _____ Phone number: _____
Your application for Energy Assistance did not show enough income to pay your monthly bills. Please complete this form to tell us how your living expenses were paid for the month of: _____ (full month prior to application date)
IMPORTANT: Your application may be denied if you do not complete this form.

List your monthly bills:

Bill	Monthly amount	Bill	Monthly amount
Rent/Mortgage		Car Payment/Insurance	
Food		Gas	
Heat		Cable/Internet	
Electric		Personal Items	
Phone/Cell		Other Expenses	

How are you paying your monthly bills with zero income? If you have not been paying your monthly bills, please explain.

If someone helped pay your bills in the month listed above, list their name below:

Name: _____ Total:$_____
Name: _____ Total:$_____

Do you live with a friend or relative? and are they listed in the application ☐ Yes ☐ No

If Yes, list name and phone number:

During the month listed above, did anyone living in your home have these sources of income?

Check all that apply and **provide proof of with this form**:
☐Full-time job ☐Part-time job ☐Self-employed ☐Workers Compensation ☐Unemployment ☐Social Security/SSI ☐Annuity Payments ☐Pension ☐Child Support ☐Rental Income ☐County/Government Program ☐Working for cash ☐Other_____

Check all that apply: (no proof required)
☐Emergency or Housing Assistance ☐Earned Income Credit ☐Savings ☐Home Equity Loan ☐Other Loans ☐Credit Card ☐Irregular Insurance Benefits

List all unemployed household members:

Name _____ Last date worked: _____
Name _____ Last date worked: _____
Name _____ Last date worked: _____
Name _____ Last date worked: _____

Payments made by others to provide support for your household are considered income.
By signing this form, I affirm that I believe these facts are accurate and true. I give the local LIHEAP Service Provider my permission to verify this information. I may be held civilly or criminally liable under federal or state law for knowingly making false or fraudulent statements.

Applicant's Signature: _____Date: _____

Tennessee Housing Development Agency

Verification of Disability

PART I: APPLICANT INFORMATION

APPLICANT NAME: _____ **DATE:** _____

CURRENT ADDRESS: _____

PART II: PERSON WITH DISABILITIES INFORMATION & INSTRUCTIONS

NAME OF HOUSEHOLD MEMBER WITH DISABILITIES: _____

LAST FOUR OF SS#: xxx-xx- _____

The above-named individual is an applicant for, or a participant in, a federally funded program operated by Upper Cumberland Human Resource Agency (UCHRA) and in partnership with the Tennessee Housing Development Agency (THDA) and has stated they are permanently disabled. Disability must be verified to determine full qualifying factors for the Low -Income Home Energy Assistance Program (LIHEAP). Your prompt completion of this form is appreciated.

PLEASE COMPLETE THE MEDICAL CERTIFICATION

PART III: MEDICAL CERTIFICAL OF NEED – to be completed by Physician/Health Care Professional

Disability Definition

Disability is defined as meeting **one or more** of the following criteria:

1. **Substantial Gainful Activity Limitation:**
   An inability to engage in any substantial gainful activity due to a medically determinable physical or mental impairment:
   - That is expected to result in death, **or**
   - Has lasted or is expected to last for a continuous period of not less than 12 months.
2. **Severe Chronic Disability:**
   A severe chronic disability that:
   - Is attributable to a mental or physical impairment, or a combination of impairments;
   - Is manifested before the individual attains age 22;
   - Is likely to continue indefinitely;

- Results in substantial functional limitations in **three or more** of the following areas of major life activity:
  - (a) Self-care
  - (b) Receptive and expressive language
  - (c) Learning
  - (d) Mobility
  - (e) Self-direction
  - (f) Capacity for independent living
  - (g) Economic self-sufficiency
- Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services of lifelong or extended duration that are individually planned and coordinated.

3. **Independent Living Impairment:**
   A physical or mental impairment that:
   - Is expected to be of long-continued and indefinite duration;
   - Substantially impedes the person's ability to live independently;
   - Is of such a nature that the person's ability to live independently could be improved by more suitable housing conditions.

CERTIFICATION

I, the undersigned **physician/health care professional**, do hereby certify that the individual listed below meets the definition of disability as outlined above.

Please check all applicable subsection(s):

☐ 1. Substantial Gainful Activity Limitation
☐ 2. Severe Chronic Disability
☐ 3. Independent Living Impairment
☐ **None of the above**

Name of Individual: _____
Date of Certification: _____

Printed Name of Certifying Professional: _____
Title/Profession: _____
Signature: _____
License Number: _____ **State:** _____
Phone Number: _____

SIGNATURE OF PHYSICIAN/HEALTH CARE PROFESSIONAL:

SIGNATURE DATE

Note: Title 18, Section 1001 of the United States Code, states that a person who knowingly and willingly makes false statements to any department or agency of the United States or the Department of Health and Human Services as conducted by the LIHEAP Program through the State of Tennessee.