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

*Application is not complete without applicant signature on page 2

Date Application Received:

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

☐ Energy Assistance ☐ Crisis Assistance

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

If yes, which agency provided assistance? ____________________

Applicant Name:			Telephone: Cell: Permission to Text? Y N
Current Address:	City:	State:	Zip:
Applicant Email:	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	Relation to Applicant	Social Security Number	Date of Birth	Age	Sex	Race (optional)	Highest Grade Completed	Vet or Active Military	Assistance for Disability?	Health Insurance	Income	Type of Income or Assistance
		Applicant							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	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	Y or N	Y or N	

Family Type: *Please check one:*

- Single Individual ☐
- Female Single Parent ☐
- Male Single Parent ☐
- Adult(s) with Child(ren) ☐
- Adult(s) without Child(ren) ☐
- Other ☐

SELF DECLARATION OF DISABILITY (Please use additional paper if more space is needed)

NAME OF HOUSEHOLD MEMBER AND PLEASE STATE PERMANENT DISABILITY:

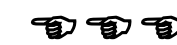
DOES HOUSEHOLD MEMBER HAVE A SIGNED MEDICAL STATEMENT THAT REQUIRES LIFE SUPPORT EQUIPMENT? YES NO (circle)

NAME OF HOUSEHOLD MEMBER AND PLEASE STATE PERMANENT DISABILITY:

DOES HOUSEHOLD MEMBER HAVE A SIGNED MEDICAL STATEMENT THAT REQUIRES LIFE SUPPORT EQUIPMENT? YES NO (circle)

NAME OF HOUSEHOLD MEMBER AND PLEASE STATE PERMANENT DISABILITY:

DOES HOUSEHOLD MEMBER HAVE A SIGNED MEDICAL STATEMENT THAT REQUIRES LIFE SUPPORT EQUIPMENT? YES NO (circle)

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. Use additional paper if more space is needed. Wages are only listed for household members 18 or older.

HOUSEHOLD MEMBER NAME	SOURCE OF INCOME	GROSS MONTHLY INCOME	IF WAGES, HOW OFTEN PAID AND EMPLOYMENT START DATE

◆◆◆ YOU MUST ATTACH CURRENT INCOME DOCUMENTATION FOR EVERY PERSON IN THE HOUSEHOLD ◆◆◆

HOUSING (Please check one) ☐ **OWN** ☐ **RENT** ☐ **SECTION 8** ☐ **PUBLIC HOUSING AUTHORITY** If Utilities are in Public Housing or Section 8 name, Amount of Utility "Overage" $ ____________

UTILITY COMPANY TO RECEIVE PAYMENT: (YOUR FIRST CHOICE)

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.

UTILITY COMPANY TO RECEIVE PAYMENT: (SECOND CHOICE)

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.

***** PLEASE ATTACH ANNUAL ENERGY USAGE DOCUMENTATION *****

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

Are you interested in learning more about the Weatherization Program? Yes ☐ No ☐

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

Do you have a utility disconnect notice, or are you past due? Y or N

Do you have less than $25 on a pre-paid utility account? Y or N

If Y to either question, be sure to attach documentation.

In addition you must meet one of the following criteria:

Do you have a household member 60 or older, or below 6?
Do you have a household member with a disability?
Do you have a household member that is a veteran or active military?
Is your household is experiencing a qualifying uncontrollable circumstance?

Please contact your local agency to discuss.

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 NOT BE SHARED WITH ANY OTHER PERSONS OR AGENCIES EXCEPT FOR PURPOSES DIRECTLY RELATED TO THE ADMINISTRATION OF THE PROGRAM (ILIHEAP). 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 UTIITY 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:

SIGNATURE OF DETERMINING AGENCY OFFICIAL: ______________________ *DATE CERTIFIED:* ____________