West Virginia Department of Health and Human Resources (DHHR)
APPLICATION FOR LOW INCOME ENERGY ASSISTANCE PROGRAM (LIEAP)

☐ Regular LIEAP
☐ Emergency LIEAP

I. IDENTIFYING INFORMATION

A. Name and Mailing Address of Applicant:

Name ______________________

Address ______________________

City ____________ County ____________

State ________ Zip ________ Phone ________

If you do not have a telephone, please supply the name of a relative or neighbor who will take a message for you.

Name ____________ Phone ____________

B. Check any benefit being received by you or a member of your household: ☐ SNAP Benefits ☐ WV WORKS ☐ Medicaid

C. Directions to your home: ______________________

D. Race (check one or more):
☐ White ☐ Black ☐ American Indian ☐ Asian

E. Ethnicity: ☐ Hispanic ☐ Non-Hispanic
If other race, please explain: ______________________

F. List the following information about yourself (Applicant) and ALL persons in your household. This includes family members and all others living under the same roof:

Full Name	Is this person a U.S. Citizen?	Birth Date mm/dd/yy	How is this person related to the Applicant?	Social Security Number	Total Monthly Income Before Deductions	
					Source or Name of Employer	Amount
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

II. HOME HEATING INFORMATION

Instructions: Please check the correct box that applies to your household after each question and enter written statements where required.

A. What is your current living arrangement?
☐ House/apartment/mobile home ☐ No shelter/homeless
☐ Institution ☐ Other (explain) ____________

B. Is anyone in your household disabled or blind?
☐ Yes ☐ No

C. Do you or someone in your household pay for your home heating costs?
☐ Yes ☐ No
If yes, what is the average monthly cost? ____________
If no, who pays? ____________

D. How do you heat your home?
(Check the item that corresponds to your primary source of home heating.)
PLEASE CHECK ONLY ONE.
☐ Natural gas furnace
☐ Liquefied gas (petroleum, propane, etc.)
☐ Coal
☐ Wood or wood products
☐ Electric furnace

☐ Fuel oil or kerosene furnace
☐ Baseboard heat
☐ Space heater (type) ____________
☐ Other ____________

E. Main heating source (same source as Question D)
Company/Vendor ____________
Account # ____________
Is your heating source included in your rent?
☐ Yes ☐ No

Is the name on your heating bill different from the applicant's name?
☐ Yes ☐ No
If yes, what is the name?
First ____________ Last ____________
Do you share a main heating source with another household?
☐ Yes ☐ No

F. Electric
Company/Vendor ____________
Account # ____________
Is your electricity included in your rent?
☐ Yes ☐ No
Is the name on your heating bill different from the applicant's name?
☐ Yes ☐ No
If yes, what is the name?
First ____________ Last ____________
Do you share an electric meter with another household?
☐ Yes ☐ No

G. Do any of these apply to you today?
Already disconnected ☐ Yes ☐ No
Company name ____________
Received a disconnect notice ☐ Yes ☐ No
Company name ____________
Past due bill ☐ Yes ☐ No
Company name ____________

Are you low on fuel/wood/coal (less than 3 days remaining)?
☐ Yes ☐ No
Are you out of fuel/wood/coal?
☐ Yes ☐ No
Non-working furnace/ boiler/heat system?
☐ Yes ☐ No

III. SIGNATURES AND STATEMENTS OF LIABILITY

Place a check in the appropriate block with each statement.

☐ Yes ☐ No — I certify that I have read or had read to me all statements on this form and I do understand all questions. I further certify that all information given is true and correct to the best of my knowledge.

☐ Yes ☐ No — I understand I may request a hearing if I am not satisfied with any decision of the local Department of Health and Human Resources (DHHR) office in determining my eligibility for LIEAP or the amount of benefits approved, or if I feel that I have been discriminated against because of race, color, national origin, sex, age, religious or political beliefs, or because I am disabled, that I may be represented by an attorney at a fair hearing but that DHHR or any of its authorized representatives will not pay for these legal services; and that LIEAP intake will close without prior notice.

☐ Yes ☐ No — I understand that I may be asked to provide additional information or verify any or all information entered on this application form and that I will cooperate by providing such information as required in determining my eligibility for LIEAP, and I authorize DHHR to use and share all such information with other agencies, organizations, or entities to verify eligibility for LIEAP and the amount of benefits.

☐ Yes ☐ No — I understand that the date of application is the date I submit the completed form along with all required verifications and information, and that missing information may result in delay and/or denial of LIEAP benefits.

☐ Yes ☐ No — I give my consent for my heating and electric companies to give data about my account and energy usage to DHHR contractors for the Low Income Energy Assistance Program (LIHEAP) and the Weatherization Program.

☐ Yes ☐ No — I understand that if I knowingly provide false or fraudulent information that is used in connection with the eligibility determination for LIEAP, I may be subject, upon conviction, to fines or imprisonment or both. I understand I will be required to repay benefits received to which I am not entitled and that my failure to repay such benefits may result in loss of future LIEAP benefits.

☐ Yes ☐ No — I agree and authorize any bank, financial institution, governmental agency or department, corporation, business concern or person to furnish any information which relates to my eligibility for and receipt of LIEAP to DHHR or any of its authorized representatives, and understand DHHR may use or share such information to verify my eligibility for and the amount of benefits.

☐ Yes ☐ No — I understand that I will be notified in writing within 30 days from the date my completed application is received by DHHR of the decision made on my application and that I may request a hearing if I have not been notified within 30 days. If I receive a direct payment, I understand it must be used to pay for the cost of primary home heating and that a receipt which verifies my payment for this must be submitted with my application for Emergency LIEAP. I understand that if I am found eligible, I am entitled to only one Regular LIEAP payment and one Emergency LIEAP payment during the LIEAP season.

MAIL THIS APPLICATION TO YOUR LOCAL DHHR OFFICE ONLY - NOT TO YOUR HEATING SUPPLIER. YOU MAY ALSO TAKE IT TO YOUR LOCAL COMMUNITY ACTION AGENCY OR SENIOR CENTER.

PLEASE PROVIDE YOUR ELECTRIC BILL and YOUR MAIN HEATING SOURCE BILL WITH THIS APPLICATION. If electric is your main heat source, you will only need to provide the electric bill; otherwise, please provide both.

______________________________ ________________
Your Signature — Date

______________________________ ________________
Signature of Person Who Helped You Fill Out This Form — Date

This application cannot be processed unless all information requested has been entered or attached and it is signed and dated by you and the person who assisted you.

West Virginia Department of Health and Human Resources

ZERO INCOME/HOME HEATING COST VERIFICATION FORM

I hereby verify that my income for the month of ______________, ______ is/will be zero.

My living expenses are:

☐	Food	☐	Home Heating
☐	Clothing	☐	Utilities
☐	Shelter	☐	Other ____________________________

Please state below how you have provided for the costs of the items circled above:

____
____
____
____
____
____
____
____

____________________________________ ____________________________
Applicant's Signature Date

You must obtain the signature, address and phone number of the person who can verify the information you provided above. This must be entered below before a decision can be made on your application. Return this form with the required information as instructed by the Worker.

I certify that the above information provided by ________________________ is true and correct to the best of my knowledge.

Name: ____

Address: ____

____

Phone: ____

____________________________________ ____________________________
Worker's Signature Date Issued

DFA-LIEAP- 4 (New 10/06)

PRIDE Community Services, Inc.

LIEAP APPLICATIONS AVAILABLE FRIDAY, JANUARY 22, 2021 – THURSDAY, JANUARY 28, 2021 AT PRIDE COMMUNITY SERVICES, INC.

APPLICATIONS ARE AVAILABLE FOR ANYONE WHO HAS NOT RECEIVED LIEAP ASSISTANCE DURING THE 2020-2021 WINTER.

COMPLETED APPLICATIONS MUST BE RETURNED BY JANUARY 28, 2021.

BRING THE FOLLOWING ITEMS TO COMPLETE AN APPLICATION:

- NAMES, BIRTHDATES, SOCIAL SECURITY NUMBERS OF HOUSEHOLD MEMBERS
- PROOF OF HOUSEHOLD INCOME (PLEASE SEE INCOME GUIDELINES BELOW)
- CURRENT ELECTRIC BILL AND MAIN SOURCE OF HEATING BILL (IF USING ELECTRIC FOR HEAT THAT IS THE ONLY BILL NEEDED)

Income limit for FY 2021 is 60% of the State Median Income.

Household Size	Gross Monthly Income Limit
1	$1,931
2	$2,525
3	$3,119
4	$3,713
5	$4,307
6	$4,901
7	$5,495
8	$6,089
9	$6,683
10	$7,277

For additional household members, please add $594. Households whose income exceeds the maximum amount are not eligible.

West Virginia Department of Health and Human Resources

LOW-INCOME ENERGY ASSISTANCE PROGRAM (LIEAP)

Instructions for Completing the Application Form

1. In order to be considered for home heating assistance, you must complete the application form. All questions on pages 1, 2 and 3 must be answered. (Page 4, Section IV is for agency use only.)

2. Be sure you enter your name, address and telephone number at the top of page 1. Also, enter the names, birth dates and Social Security Numbers of all persons, including yourself, living in your household whether or not they are family members.

3. Make sure that the gross monthly income for you and each person living in your household is entered. If you or anyone in your household receive earnings from employment, the total household monthly income must be verified. You may verify income by providing current paycheck stubs, SSI or Social Security award letters, etc., when you return your application to any of the three offices listed below in number 6.

4. If you report no or "zero" income on the application form, please complete and return the enclosed zero income form.

5. Please read each question on pages 2 and 3 carefully, providing answers as instructed. Make sure you sign and date the form IN INK. If someone helps you complete the form, he or she must also sign and date the form.

6. If you need assistance completing the application, you may contact or visit your local Community Action agency, your local senior citizens' center or your local Department of Health and Human Resources (DHHR) office.

   Please provide your electric bill and/or your main heating source bill with this application.

   If you wish to return the completed application by mail, you must mail the application to your local DHHR office only. Do Not Mail It To Your Utility Company. Applicants may also use inROADS to apply over the internet at www.wvinroads.org.

7. If your heating account is in someone else's name, you must identify the relationship of this person to you (relative, former roommate or spouse, landlord, etc.). Failure to do so could delay crediting your LIEAP payment to your account.

If you need assistance or further information concerning LIEAP, please call this toll-free number: 1-800-642-8589.

INCOME GUIDELINES FOR LIEAP FY 2017 ARE SHOWN ON THE BACK OF THIS SHEET

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOUCES (DHHR)
SUPPLEMENTAL LIEAP FORM

I. FOR DHHR AND OTHER AGENCY USE ONLY

IMPORTANT: The Worker **MUST** ensure this section is completed in its entirety in order for the application to be complete.

Application Received Date: ______________ How Received: ☐ Through Mail (DHHR Only) ☐ Office Visit to DHHR ☐ Visit to Other Agency

Name of other agency that received the application: ______________

A. Did application include required verifications as specified on instruction sheet? ☐ Yes ☐ No

Indicate how income was verified, as appropriate:

____

____

____

B. Was additional verification requested? ☐ Yes ☐ No

Indicate date application was considered complete: ______________

______________ Signature & title of worker from other agency

______________ Date

II. C. Was application complete? ☐ Yes ☐ No

If no, what was missing? ______________

____

Incomplete applications will be denied unless Applicant supplies missing information within 10 days or Worker is able to obtain the information within the 10-day period.

D. Date of application: ______________ Date of decision: ______________

E. Date entered in RAPIDS: ______________ Decision: ☐ Approved ☐ Denied

The date of application is the date the form is received by DHHR or the other agency, or date postmarked if received after LIEAP closes.

F. Recording (must include account number, account name, and vendor number in CMCC):

____

____

____

____

G. BIRS completed for Regular LIEAP? Check IQPS to make sure payment is scheduled.

______________ DHHR worker's signature

______________ Date

DFA-LIEAP-1b (Rev. 12/16)

PRIDE Community Services, Inc. **DBA FACS Pro Customer Intake Form**

Intake Date ____/____/______ (MM DD YYYY)	**Staff Completing Intake** ______________________

Address / Demographics

First Name ______________________ **MI**_____ **Last Name** ______________________ **Suffix**_____

Mailing Address	______________________ ______________________ CITY ______ STATE ______ ZIP CODE ______	**Physical Address**	______________________ ______________________ CITY ______ STATE ______ ZIP CODE ______
Phone	Home- (____) _____ - ______ Cell- (____) _____ - ______ Work- (____) _____ - ______ X____	**Message**	Accept Text Messages? ☐ Yes ☐ No E-mail- ______________________ ☐ Block from Search
SS#	______ - ______ - ______ ☐ Partial SSN Reported ☐ Confidential ☐ Unavailable ☐ Refused ☐ Unknown	**Date of Birth**	____/____/______ (MM DD YYYY) ☐ Full DOB Reported ☐ Partial DOB Reported ☐ Don't Know ☐ Refused
Gender	☐ Male ☐ Female ☐ Other	**Ethnicity**	☐ Non-Hispanic/Non-Latino ☐ Hispanic/Latino
Race	☐ American Indian or Alaska Native ☐ Asian ☐ Bi-racial or Multi-racial ☐ Black or African-American ☐ Caucasian or White ☐ Middle Eastern ☐ Native Hawaiian or Pacific Islander ☐ Unspecified	**Marital Status**	☐ Single ☐ Divorced ☐ Married ☐ Separated ☐ Partner ☐ Widowed
		Tribe	☐ None ☐ Blackfoot ☐ Cherokee ☐ Choctaw ☐ Pawnee ☐ Pima
Primary Language	☐ African ☐ North American/Alaska ☐ Caribbean ☐ Other ☐ Creole ☐ Pacific Island ☐ East Asian ☐ Spanish ☐ English ☐ European/Slavic ☐ German ☐ Middle Eastern/South Asian ☐ Native Central/South American or Mexican	**Secondary Language**	☐ African ☐ North American/Alaska ☐ Caribbean ☐ Other ☐ Creole ☐ Pacific Island ☐ East Asian ☐ Spanish ☐ English ☐ European/Slavic ☐ German ☐ Middle Eastern/South Asian ☐ Native Central/South American or Mexican
Health Insurance	☐ Direct-Purchase ☐ None ☐ Employment Based ☐ Unknown ☐ Medicaid ☐ Medicare ☐ Military Health Care ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults	**Education Level**	☐ 0-8 ☐ 9-12 Non-Graduate ☐ High School Graduate/GED ☐ Some College/Certificate/Trade ☐ 2-4 Year College Graduate ☐ Post Graduate Degree ☐ Unknown
Disabling Condition	☐ Yes ☐ No ☐ Unknown	**Military Status**	☐ Active Military ☐ None ☐ Veteran ☐ Unknown

PRIDE Community Services, Inc. **DBA FACS Pro Customer Intake Form**

Household Type	☐ Single Person (living alone) ☐ Single Person (living with partner) ☐ Single Person (living with others) ☐ Two Adults (NO children) ☐ Single parent Female (living with children) ☐ Single parent Male (living with children) ☐ Two Parent Household (living with children) ☐ Multiple Adults (living with children) ☐ Grandparent(s) (raising grandchildren)	**Housing**	☐ Own ☐ Rent- Subsidized (HUD, Section 8, etc.) ☐ Rent- Unsubsidized ☐ Homeless ☐ Incarcerated ☐ Living with Friends or Family ☐ Transitional / Shelter ☐ Unknown
Charact. (check all that apply)	☐ Applicant ☐ Debarred ☐ Employee, Relative of Board Member ☐ Youth (14-24) not working or in school ☐ No Heat Emergency ☐ Foster Child ☐ Dwelling Type Override ☐ Referred by DHHR		☐ Vision Impaired ☐ Hearing Impaired ☐ Head Start /EHS – Foster Parent of Child ☐ Head Start /EHS – Parent of Child ☐ Head Start /EHS – Dual Custody Agreement ☐ Head Start /EHS – Guardian of Child ☐ Head Start /EHS – Over Income Exception ☐ Head Start – Board of Edu. 4 yr. old

Income

Monthly Income Sources for Household Member

☐ No Financial Resources

☐ Employment Earnings.................................. $________.00

☐ Other Income Sources

- ☐ TANF.. $________.00
- ☐ SSI.. $________.00
- ☐ SSDI.. $________.00
- ☐ VA Service-Connected Disability Compensation ...... $________.00
- ☐ VA Non-Service Connected Disability Pension .... $________.00
- ☐ Private Disability Insurance.............................. $________.00
- ☐ Worker's Compensation.................................... $________.00
- ☐ Retirement Income from Social Security................ $________.00
- ☐ Pension... $________.00
- ☐ Child Support.. $________.00
- ☐ Alimony or other Spousal Support........................ $________.00
- ☐ Unemployment Insurance.................................. $________.00
- ☐ EITC... $________.00
- ☐ Other... $________.00

☐ Non-Cash Benefits

☐ SNAP	☐ Permanent Supportive Housing
☐ WIC	☐ HUD-VASH
☐ LIHEAP	☐ Childcare Voucher
☐ Housing Choice Voucher	☐ Affordable Care Act Subsidy
☐ Public Housing	☐ Other

Total Monthly Income.. $________.00

Employment

Work Status

Is this person employed?
☐ Yes ☐ No ☐ Unknown

If yes or no, what is her/his status?
☐ Employed Full-time with benefits
☐ Employed Full-time without benefits
☐ Employed Part-time
☐ Migrant Seasonal Farm Worker
☐ Retired
☐ Unemployed (Long-term more than 6 months)
☐ Unemployed (Not in Labor Force)
☐ Unemployed (Short-term 6 months or less)

Current Employer Name: ____________________

Employed Since: ___/___/______ (MM DD YYYY)

2nd Current Employer Name: ____________________

Employed Since: ___/___/______ (MM DD YYYY)

PRIDE Community Services, Inc.

dditional Household Member

First Name ____________________ MI______ Last Name ____________________ Suffix______

Relationship to Head of Household				
☐ Aunt	☐ Foster Child	☐ Nephew	☐ Spouse	
☐ Brother	☐ Foster Parent	☐ Niece	☐ Stepchild	
☐ Custodial Parent	☐ Grandchild	☐ Other	☐ Uncle	
☐ Daughter	☐ Grandparent	☐ Partner		
☐ Father	☐ In-law	☐ Sister		
☐ Former Spouse	☐ Mother	☐ Son		

Phone	Home- (____) _____ - _______ Cell- (____) _____ - _______ Work- (____) _____ - _______ X____	**Message**	Accept Text Messages? ☐ Yes ☐ No E-mail- ____________ ☐ Block from Search
SS#	_______ - _____ - _______ ☐ Partial SSN Reported ☐ Confidential ☐ Unavailable ☐ Refused ☐ Unknown	**Date of Birth**	______/______/______ MM DD YYYY ☐ Full DOB Reported ☐ Partial DOB Reported ☐ Don't Know ☐ Refused
Gender	☐ Male ☐ Female ☐ Other	**Marital Status**	☐ Single ☐ Divorced ☐ Married ☐ Separated ☐ Partner ☐ Widowed
Race	☐ American Indian or Alaska Native ☐ Asian ☐ Bi-racial or Multi-racial ☐ Black or African-American ☐ Caucasian or White ☐ Middle Eastern ☐ Native Hawaiian or Pacific Islander ☐ Unspecified	**Ethnicity**	☐ Non-Hispanic/Non-Latino ☐ Hispanic/Latino
		Tribe	☐ None ☐ Blackfoot ☐ Cherokee ☐ Choctaw ☐ Pawnee ☐ Pima
Primary Language	☐ African ☐ North American/Alaska ☐ Caribbean ☐ Other ☐ Creole ☐ Pacific Island ☐ East Asian ☐ Spanish ☐ English ☐ European/Slavic ☐ German ☐ Middle Eastern/South Asian ☐ Native Central/South American or Mexican	**Secondary Language**	☐ African ☐ North American/Alaska ☐ Caribbean ☐ Other ☐ Creole ☐ Pacific Island ☐ East Asian ☐ Spanish ☐ English ☐ European/Slavic ☐ German ☐ Middle Eastern/South Asian ☐ Native Central/South American or Mexican
Health Insurance	☐ Direct-Purchase ☐ None ☐ Employment Based ☐ Unknown ☐ Medicaid ☐ Medicare ☐ Military Health Care ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults	**Education Level**	☐ 0-8 ☐ 9-12 Non-Graduate ☐ High School Graduate/GED ☐ Some College/Certificate/Trade ☐ 2-4 Year College Graduate ☐ Post Graduate Degree ☐ Unknown
Disabling Condition	☐ Yes ☐ No ☐ Unknown	**Military Status**	☐ Active Military ☐ None ☐ Veteran ☐ Unknown

PRIDE Community Services, Inc.

DBA FACS Pro Customer Intake Form

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Charact. (check all that apply)	☐ Applicant ☐ Debarred ☐ Employee, Relative of Board Member ☐ Youth (14-24) not working or in school ☐ No Heat Emergency ☐ Foster Child ☐ Dwelling Type Override ☐ Referred by DHHR		☐ Vision Impaired ☐ Hearing Impaired ☐ Head Start /EHS – Foster Parent of Child ☐ Head Start /EHS – Parent of Child ☐ Head Start /EHS – Dual Custody Agreement ☐ Head Start /EHS – Guardian of Child ☐ Head Start /EHS – Over Income Exception ☐ Head Start – Board of Edu. 4 yr. old

Income

Monthly Income Sources for Household Member

☐ No Financial Resources................................ *(No-Income Affidavit Required)*

☐ Employment Earnings.................................... $__________.00

☐ Other Income Sources

- ☐ TANF.. $__________.00
- ☐ SSI.. $__________.00
- ☐ SSDI.. $__________.00
- ☐ VA Service-Connected Disability Compensation ...... $__________.00
- ☐ VA Non-Service Connected Disability Pension .... $__________.00
- ☐ Private Disability Insurance.......................... $__________.00
- ☐ Worker's Compensation................................ $__________.00
- ☐ Retirement Income from Social Security................. $__________.00
- ☐ Pension.. $__________.00
- ☐ Child Support.. $__________.00
- ☐ Alimony or other Spousal Support........................ $__________.00
- ☐ Unemployment Insurance.............................. $__________.00
- ☐ EITC.. $__________.00
- ☐ Other.. $__________.00

☐ Non-Cash Benefits

☐ SNAP	☐ Permanent Supportive Housing
☐ WIC	☐ HUD-VASH
☐ LIHEAP	☐ Childcare Voucher
☐ Housing Choice Voucher	☐ Affordable Care Act Subsidy
☐ Public Housing	☐ Other

Total Monthly Income.. $__________.00

Employment

Work Status

Is this person employed?
☐ Yes ☐ No ☐ Unknown

If yes or no, what is her/his status?
- ☐ Employed Full-time with benefits
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- ☐ Employed Part-time
- ☐ Migrant Seasonal Farm Worker
- ☐ Retired
- ☐ Unemployed (Long-term more than 6 months)
- ☐ Unemployed (Not in Labor Force)
- ☐ Unemployed (Short-term 6 months or less)

Current Employer Name: ______________________________

Employed Since: ____/____/________ (MM DD YYYY)

2nd Current Employer Name: ______________________________

Employed Since: ____/____/________ (MM DD YYYY)

Customer Consent Form

I, ______________________________give PRIDE Community Services, Inc. consent to release, obtain, store and share all pertinent identifying and non-personally identifying social, medical and other information about myself or other members of my household that will allow me to benefit from services offered. In granting such permission, I understand that such information will be stored in a secure electronic data system. My information will remain confidential and that such information will only be used for my benefit or to benefit other members of my household. Only authorized personnel will share client information needed for service delivery, program eligibility, to track demographic trends, service patterns and the client outcomes achieved. Non-personally identifying information may also be used for the purposes of research and reporting to other service agencies, current and potential program funding sources and other programs offered by PRIDE Community Services, Inc. I release PRIDE Community Services, Inc. and its staff from any legal liability for disclosing or acquiring information that I have permitted by signing this form. Unless I make a formal request to PRIDE Community Services, Inc. that I no longer want to participate in the services offered, this release will remain in force indefinitely as of today. The statements made by me on this consent form are true, correct and complete to the best of my knowledge as of the date signed.

______________________________________ ______________

ıstomer Signature Date

______________________________________ ______________

Signature of CAA Staff Member Date

PRIDE Community Services, Inc., its agent, partners and funding sources do not discriminate on the basis of race, color, sex, religion, national origin, disability or marital status.