



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 _____

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:

G. Do you or anyone in your household need an accommodation because of a condition that would prevent you from completing the application process: (if yes, please explain) _____

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: _____

	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 which 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 which 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

Have you or anyone in your household been affected by COVID-19

Yes No

III. SIGNATURES AND STATEMENTS OF LIABILITY

Place a check in the appropriate block with each statement.

Yes 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.
 No

Yes I understand I may request a hearing if I am not satisfied with any decision of the local 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.
 No

Yes 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.
 No

Yes 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.
 No

Yes I give my consent for my heating and electric companies to give data about my account and energy usage to the West Virginia Department of Health and Human Resources (DHHR), contractors for the Low Income Energy Assistance Program (LIEAP) and the Weatherization Program.
 No

Yes 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.
 No

Yes 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.
 No

Yes 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.
 No

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.

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

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

Income	
Monthly Income Sources for Household Member	<input type="checkbox"/> No Financial Resources <input type="checkbox"/> Employment Earnings..... \$ _____ .00 <input type="checkbox"/> Other Income Sources <input type="checkbox"/> TANF..... \$ _____ .00 <input type="checkbox"/> SSI..... \$ _____ .00 <input type="checkbox"/> SSDI..... \$ _____ .00 <input type="checkbox"/> VA Service-Connected Disability Compensation \$ _____ .00 <input type="checkbox"/> VA Non-Service Connected Disability Pension \$ _____ .00 <input type="checkbox"/> Private Disability Insurance..... \$ _____ .00 <input type="checkbox"/> Worker's Compensation..... \$ _____ .00 <input type="checkbox"/> Retirement Income from Social Security..... \$ _____ .00 <input type="checkbox"/> Pension..... \$ _____ .00 <input type="checkbox"/> Child Support..... \$ _____ .00 <input type="checkbox"/> Alimony or other Spousal Support..... \$ _____ .00 <input type="checkbox"/> Unemployment Insurance..... \$ _____ .00 <input type="checkbox"/> EITC..... \$ _____ .00 <input type="checkbox"/> Other..... \$ _____ .00 <input type="checkbox"/> Non-Cash Benefits <input type="checkbox"/> SNAP <input type="checkbox"/> WIC <input type="checkbox"/> LIHEAP <input type="checkbox"/> Housing Choice Voucher <input type="checkbox"/> Public Housing <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> HUD-VASH <input type="checkbox"/> Childcare Voucher <input type="checkbox"/> Affordable Care Act Subsidy <input type="checkbox"/> Other Total Monthly Income..... \$ _____ .00

Employment	
Work Status	Is this person employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes or no, what is her/his status? <input type="checkbox"/> Employed Full-time with benefits <input type="checkbox"/> Employed Full-time without benefits <input type="checkbox"/> Employed Part-time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed (Long-term more than 6 months) <input type="checkbox"/> Unemployed (Not in Labor Force) <input type="checkbox"/> Unemployed (Short-term 6 months or less)
	Current Employer Name: <hr/> Employed Since: <u> </u> / <u> </u> / <u> </u> MM DD YYYY 2nd Current Employer Name: <hr/> Employed Since: <u> </u> / <u> </u> / <u> </u> MM DD YYYY

Additional Household Member

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

Relationship to Head of Household	<input type="checkbox"/> Aunt	<input type="checkbox"/> Foster Child	<input type="checkbox"/> Nephew	<input type="checkbox"/> Spouse
	<input type="checkbox"/> Brother	<input type="checkbox"/> Foster Parent	<input type="checkbox"/> Niece	<input type="checkbox"/> Stepchild
	<input type="checkbox"/> Custodial Parent	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Other	<input type="checkbox"/> Uncle
	<input type="checkbox"/> Daughter	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Partner	
	<input type="checkbox"/> Father	<input type="checkbox"/> In-law	<input type="checkbox"/> Sister	
	<input type="checkbox"/> Former Spouse	<input type="checkbox"/> Mother	<input type="checkbox"/> Son	

Phone	Home- (____) _____ - _____ Cell- (____) _____ - _____ Work- (____) _____ - _____ X_____	Message	Accept Text Messages? <input type="checkbox"/> Yes <input type="checkbox"/> No E-mail- _____ <input type="checkbox"/> Block from Search
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Income																																							
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Employment		
Work Status	Is this person employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes or no, what is her/his status? <input type="checkbox"/> Employed Full-time with benefits <input type="checkbox"/> Employed Full-time without benefits <input type="checkbox"/> Employed Part-time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed (Long-term more than 6 months) <input type="checkbox"/> Unemployed (Not in Labor Force) <input type="checkbox"/> Unemployed (Short-term 6 months or less)	Current Employer Name: <hr/> Employed Since: <u> </u> / <u> </u> / <u> </u> MM DD YYYY 2nd Current Employer Name: <hr/> Employed Since: <u> </u> / <u> </u> / <u> </u> 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.

Customer 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.