



ARKANSAS ENERGY OFFICE ARKANSAS HOME ENERGY ASSISTANCE PROGRAM APPLICATION



If you need this material in a different format, such as large print,
CONTACT YOUR LOCAL COMMUNITY ACTION AGENCY (CAA)

**ENVIRONMENTAL
QUALITY**

FOR AGENCY USE ONLY				REGISTER NUMBER(S)			
APPLICATION DATE				REGULAR ASSISTANCE			
APPLICATION TIME				CRISIS INTERVENTION			
a.m.		p.m.					
DISPOSITION TIME LIMIT				SUPPLEMENTAL			
<input type="checkbox"/> 18 HOURS		<input type="checkbox"/> 48 HOURS					
Interviewer		Method		Date			



- You must apply through the CAA serving the county in which you live.
- Complete all sections and attach requested documentation; failure to do so will delay processing of your application.

TO MAKE CHANGES, DO NOT WHITE OUT. CROSS-OUT AND RE-WRITE ANSWER.

Affordable Care Act (ACA) – The comprehensive health care reform law was enacted in March 2010. The law has 3 primary goals: (1) Make affordable health insurance available to more people. The law provides consumers with subsidies (“premium tax credits”) that lower costs for households with incomes between 100% and 400% of the federal poverty levels; (2) Expand the Medicaid program to cover all adults 19 – 64 years of age with income below 100% of the federal poverty level; and (3) Support innovative medical care delivery methods designed to lower the costs of health care generally.

FOR MORE INFORMATION GO TO HEALTHCARE.GOV OR CALL 1-800-318-2596

What bill(s) do you need assistance with? (Check up to Two.)

Gas Electricity Propane Fuel Oil Other: _____

● **1. APPLICANT – PLEASE PUT YOUR NAME AND INFORMATION HERE**

attach copy of ID (e.g., driver’s license) and Social Security card

Last Name		First Name		Middle Name	
Mailing Address			City	State	Zip Code
Street Address if different from mailing address			City	State	Zip Code
County of Residence	Mobile Phone Number	Home Phone Number	Email Address		
Social Security Number	Date of Birth	Age	Do you have a Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Spanish American/Hispanic <input type="checkbox"/> Oriental; Asian or Pacific Islander <input type="checkbox"/> Native American or Alaskan Native <input type="checkbox"/> Other <input type="checkbox"/> Unknown			

● **2. OTHER HOUSEHOLD MEMBERS – DO NOT INCLUDE YOURSELF**

Please list the **other** persons living in your household but not yourself. Please complete all items. (Please list additional members on a separate sheet).

NAME	RELATIONSHIP TO YOU	DATE OF BIRTH	AGE	RACE	SOCIAL SECURITY NUMBER	DISABLED?	
						YES	NO
1.							
2.							
3.							
4.							
5.							
6.							

● **3. HOUSEHOLD INCOME**

A. **WORK INCOME** - List anyone in your household who has work income (Includes self-employment, babysitting; et cetera)

YOU MUST ATTACH COPIES OF LAST MONTH'S PAY STUBS

WHO IS EMPLOYED	HOW OFTEN PAID	GROSS AMOUNT LAST MONTH	EMPLOYER NAME
1.			
2.			
3.			

B. **LAST EMPLOYMENT** – If you or any adult (18 or older) member of your household is **unemployed** at the time of the application, list your most recent employment below.

NAME	WHERE LAST EMPLOYED	WHEN EMPLOYMENT ENDED
1.		
2.		
3.		

C. **NON-WORK INCOME** – List anyone in your household who receives any of the following and **attach proof of this income**:

Child Support, Social Security Income; (SSA) Supplemental Security Income (SSI); Supplemental Security Disability Income (SSDI); TEA; Alimony; Unemployment benefits; Worker’s Compensation; Veterans Benefits; Retirement Benefits; Housing Utility Assistance Payment; any other non-work income:

WHO RECEIVES IT?	HOW OFTEN PAID	GROSS MONTHLY AMOUNT	NON-WORK INCOME FROM (SSA, RETIREMENT, ETC.)
1.			
2.			
3.			

D. **RESOURCES** – Does anyone in your home have any of the following?

RESOURCES	YES	NO	AMOUNT	WHERE	NAME(S) OF PERSON
Cash on hand					
Checking Account					
Other Bank Accounts					
Other Resources (list)					
Other Resources (list)					

CRISIS APPLICANTS ONLY: If your household is in need of crisis assistance, please indicate below:

- I have a past due balance on a utility bill. HEATING ELECTRICITY
- My home energy utility has been disconnected. HEATING ELECTRICITY
- I have received notice that my home energy utility will be disconnected. HEATING ELECTRICITY
- My heating fuel is at or below 10% of the tank capacity and the fuel supplier will not deliver additional fuel without payment.
- I have 3 weeks’ supply or less heating fuel (wood, coal, or other heating fuel not kept in a tank) and the fuel supplier will not deliver additional fuel without payment.
- I have received an eviction notice which is partly due to my failure to pay my heating and/or electricity expenses to my landlord.
- I need assistance to pay a deposit to have my utility connected/reconnected: HEATING ELECTRICITY

Is your **crisis** situation life-threatening? YES NO If yes, please explain in detail. _____

● **4. UTILITY/RENT INFORMATION**

Do you **Rent** or **Own** your home?

RENTERS ONLY – Is your energy cost included in your rent payment? YES NO

If yes, attach a copy of your lease that says utilities are included in your rent and provide:

Landlord. _____
LANDLORD’S NAME LANDLORD’S PHONE

● 5. HOME ENERGY SUPPLIER INFORMATION

You must complete information on **BOTH – PRIMARY Heating Source AND ELECTRIC – AND** include copies of **EACH** bill. My residence is ALL ELECTRIC YES NO

Name of Primary Heating Supplier:: _____ Account Number: _____
 Natural Gas Electricity Fuel oil or kerosene Propane, Butane, or LPG Other: _____

If your heating bill is **not** in your name, whose name is the account in? _____ Is the account closed? YES NO

Does this person live with you? YES NO **What is this person’s relationship to you?** _____

SECONDARY HEATING SUPPLIER IS OPTIONAL, COMPLETE ONLY IF YOU WANT ASSISTANCE WITH THIS BILL.

Name of Secondary Heating Supplier:: _____ Account Number: _____
 Natural Gas Electricity Fuel oil or kerosene Propane, Butane, or LPG Other: _____

If your heating bill is **not** in your name, whose name is the account in? _____ Is the account closed? YES NO

Does this person live with you? YES NO **What is this person’s relationship to you?** _____

Name of Electric Supplier: _____ Account Number: _____

Is the account closed? YES NO

If your electric bill is **not** in your name, whose name is the account in? _____

Does this person live with you? YES NO **What is this person’s relationship to you?** _____

● 6. VERIFICATION OF IDENTITY (ID)

You must attach proof of identity. Acceptable proof includes A **READABLE COPY** of any VALID document that reasonably establishes identity such as:

- Voter registration card
- Federal, state, or local government issued ID Card
- U.S. Military Card or dependent’s card
- A recent paycheck stub
- ID card for health benefits or other assistance
- Work or school ID card with photograph
- Driver's license or ID Card issued by a State or federal possession

● 7. WEATHERIZATION SERVICES (WAP)

Would you like to be referred for home Weatherization? YES NO If yes, may LIHEAP send your application to WAP? YES NO

● 8. APPLICANT’S RIGHTS AND RESPONSIBILITIES

FAILURE TO SIGN AND DATE A PAPER APPLICATION WILL DELAY THE PROCESSING OF YOUR LIHEAP APPLICATION.

I understand that I have the right to appeal any decision regarding this application which I consider improper, and also any delay in decision or delivery of services.

I understand that I must help establish my eligibility by providing as much information as I can about my circumstances.

I authorize the contracted agency to release information relating to my application for LIHEAP to my Energy Supplier(s) to determine eligibility. I give permission to the Arkansas Energy Office (AEO) to use information provided on this form for purposes of research, evaluation and analysis of the program.

I understand that my utility service provider will have no control over the data disclosed pursuant to this consent and will not be responsible for monitoring or taking any steps to ensure that the LIHEAP office maintains the confidentiality of the data or uses the data as I have authorized.

I understand that no person may be denied assistance on the basis of race, color, sex, age, handicap, religion, national origin, or political belief.

I understand that my signature on this application authorizes the agency to make any investigation concerning me or any household member and/or use a copy as a release of information for securing information needed to determine my eligibility for services.

I understand that if I receive assistance to which I am not entitled as a result of withholding information or knowingly providing false or fraudulent information regarding my circumstances, I must repay the cost of any assistance and may face penalty of criminal prosecution.

The information given on this application is true to the best of my knowledge and belief. I understand that this form is signed subject to penalties for perjury.

Signature of Applicant (must be same person listed in Section 1, page 1) or Authorized Representative _____ Date _____ Witness, if signed by mark _____ Date

Signature of Person Helping To Complete this Form _____ Date _____ Address of Witness _____ Date

