

LIHEAP Paper Application

Complete the attached two page application and return with the needed verification documentation. Return options: drop off at local sethra office, email to liweap@sethra.us, mail to SETHRA P.O. Box 909, Dunlap, TN 37327.

Please provide a valid contact number on the application. A SETHRA intake worker will contact you via phone once the application has been returned.

Along with the application the following documentation must be returned in order for the intake to process the application:

Valid Email Address Required

- All applicants **must have a valid email address** to begin the application process.
- If you do not currently have an email address a SETHRA intake worker can assist you in creating one during your appointment.

The following documentation must be provided for all applicants:

1. Identification Documents

- **Government-issued ID** for the **Head of Household**
- **Social Security Cards** for **all household members**
(For children under age 1, a birth certificate may be provided if the SSN card is not available.)

Both must be provided at the time of intake. Without this, we cannot move forward with the application process.

2. Proof of Income for All Household Members (Ages 18 and Over)

Income such as Survivors benefits, SSI, child support, TANF (Families First) is counted for children under 18.

Acceptable Forms of Income Verification:

Income Type	Acceptable Documentation
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Wages/Salary

Paystubs from the past 30 days (from the date of application). If unavailable, a written, signed, and dated letter from the employer on official company letterhead.

Fixed Income (Social Security, SSI, Pension, VA, Survivor Benefits)

Most recent benefit award letter **OR** current bank statement showing direct deposit. *(Client's name must be listed on the account; redact account numbers.)*

Child Support/Alimony TANF (Families First)

Official court order or child support agency printout. Printout from DHS.

Unemployment Benefits

Claim summary or benefits statement from the state unemployment website. Previous year's tax return (acceptable until April each year)

Self-Employment

OR documentation showing adjusted gross income after business expenses. A **Zero Income Declaration Form** must be completed for every household member over age 18 with no income. *Failure to provide this will result in denial. This form can be found on the THDA website-*

Zero Income

<https://dogvxws799i6n.cloudfront.net/wp-content/uploads/2027-LIHEAP-LI-03-ZERO-INCOME-FORM-English.pdf> or you can contact your local SETHRA agency for the form.

3. Verification of Disability (If Applicable)

If any household member claims a disability:

- Provide an **SSI or SSDI award letter, OR**
- A **Verification of Disability Form** signed by a licensed medical professional.
 - This document can be found on the THDA website-
<https://dogvxws799i6n.cloudfront.net/wp-content/uploads/2027-LIHEAP-LI-11-Verification-of-Disability-English-Fillable.pdf> or you can contact your local SETHRA agency for a copy.

4. Energy Burden Documentation

- **Current Utility Bill**

- **12-Months of utility bills or 12 month Utility Printout**
(If you have more than one utility provider, documentation is required for each excluding water, internet, sewer, trash etc.)

5. Emergency Documentation (If Applying for Crisis Assistance)

Provide **one or more** of the following:

- Disconnect notice or bill showing pending disconnection.
- Eviction notice due to utility-related charges or unpaid rent.
- Fuel depletion notice (indicating 20% or less in tank and delivery refused).

6. Additional Criteria Documentation

At least one of the following must be met and verified for eligibility. Documentation must be provided to continue with the application.

Situation	Required Documentation
Recent Job Loss or Death of Wage Earner (within last 12 months)	Termination notice, UI claims, death certificate, or funeral program.
Vulnerable Household Members	Presence of children aged 5 or under, or individuals aged 60 or older.
Active Military or Veteran Status	Verification of military service.
Disabled Household Members	SSI/SSDI award letters or medical disability verification form.
Life-Support Equipment Needs	Letter from a licensed medical professional or medical equipment company indicating the equipment requires utility service.
<i>Must be provided within 18 hours of request.</i>	

How to Apply:

In person or phone appointment: contact your local SETHRA office.

Bledsoe County: 423-447-2444

Grundy County: 931-592-8262

Marion County: 423-942-8876

McMinn County: 423-745-8095

Meigs County: 423-334-3305

Polk County Ducktown: 423-496-2644

Polk County Benton: 423-338-2335

Rhea County: 423-775-4010

Sequatchie County: 423-949-2191

Return paper applications:

Drop off at your local SETHRA location

Mail to SETHRA, P.O. Box 909, Dunlap, TN 37327

Email to: liheap@sethra.us

Online self-self: follow the link provided at SETHRA.us or https://thda.smartsimple.us/s_Login.jsp

2027 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:

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:	Zip:	
				TN		
Mailing Address: (if different)			City:	State:	Zip:	
Phone:		Alternate Phone:		County:		

Please select all that apply:

Do you have a utility disconnect, past due, disconnected, an eviction notice due to utility overage, unpaid rent, are running or are out of fuel, your heat/air unit 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☐ Household wage earner lost their job or died within the last 12 months☐ A household member 5 years or younger in the home☐ A household member who is a veteran or active military☐ A household member who is disabled (either receiving disability income or a verification of disability form)☐ A household member requiring life support equipment

Is your heating and or air conditioning system working properly? (circle one) Y or N

Would you like to be considered for a LIHEAP-funded repair or replacement? (circle one) Y or N

Do you give THDA and our LIHEAP Partner permission to share your name, phone number, email address, and property address with a local agency partner to coordinate service? (circle one) Y or N This does not guarantee services.

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.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	RACE	Ethnicity	US Citizen/ Qual Alien	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	Y or N	

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

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).

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

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 ☐ OTHER ☐ RENT w/ utilities included (Landlord/Tenant form required) ☐ UNKNOWN

UTILITY INFORMATION

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 its payments.

*** ATTACH 12 MONTHS OF ENERGY USAGE DOCUMENTATION FROM ALL ENERGY 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. 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.

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 LIHEAP.

Applicant Signature:

Date:

SIGNATURE OF DETERMINING AGENCY OFFICIAL:

DATE CERTIFIED:

Zero Income Form

Applicant Name: _____ Number in Household: _____

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:

IMPORTANT: Your application may be denied if you do not complete this form.

List your monthly bills:

Bill	Monthly Amount
Rent/Mortgage	_____
Food	_____
Heat	_____
Electric	_____
Phone or Cell	_____
Car Payment and Insurance	_____
Gas	_____
Personal Items	_____
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? ☐ Yes ☐ No

Are they listed on your application? ☐ Yes ☐ No If no, write their name and phone:

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

Check all that apply and provide proof 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 ☐ Alimony ☐ TANF ☐ 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: (including yourself if applicable)

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.

Approved By Applicant: _____ Date: _____

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 Social Security Number: xxx-xx _____

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

PLEASE COMPLETE THE MEDICAL CERTIFICATION

Part III: Medical Certification 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:
 - Selfcare

- Self-direction
- Receptive and expressive language
- Learning
- Mobility
- Capacity for independent living
- 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.

☐ None of the above

Name of Individual: _____

Date of Certification: _____

Printed Name of Certifying Professional: _____

Title/Professional: _____

Approved By Certifying Professional: _____

License Number: _____ State: _____ Phone Number: _____

Approved By Physician/Health Care Professional: _____ Date: _____

Self-Employment Income Form

Applicant Name: _____

Business Type: _____

This self-employment income is for the period of _____ through _____.

Have you filed taxes this current year? ☐ Yes ☐ No

If Yes, a copy of your completed return is required.

Did you file taxes last year? ☐ Yes ☐ No

If you did not file taxes this current year but you did file last year, please provide a copy of last year's tax return.

How often is income received:

☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

Income Details, Household Member 1

Date Received _____

Form: Cash, Check, Money Order _____

Amount _____

Business Expenses, type of expense and amount _____

Net Income _____

Notes _____

I, _____, certify that the forgoing is a true and accurate record of my self-employment income for the past 30 days.

Approved by Applicant: _____ Date: _____

Income Details, Household Member 2

Date Received _____

Form: Cash, Check, Money Order _____

Amount _____

Business Expenses, type of expense and amount _____

Net Income _____

Notes _____

Income Details, Household Member 3

Date Received _____

Form: Cash, Check, Money Order _____

Amount _____

Business Expenses, type of expense and amount _____

Net Income _____

Notes _____

I, _____, certify that the forgoing is a true and accurate record of my self-employment income for the past 30 days.

Approved by Applicant: _____ Date: _____

LIHEAP Landlord Tenant Energy Assistance Agreement

This form is to be used if a LIHEAP client's energy bill is included in the cost of rent paid to their landlord.

Landlord Name: _____

Tenant Name: _____

Rental Property Address: _____

Move In Date: _____

Total Monthly Rent: \$_____ Monthly Energy Costs: \$_____

Energy Bill Account #: _____ Please include a copy of the energy bill

Energy Bill Account Name: _____

Energy Vendor: _____

Landlord Certification

I agree to reduce the tenant's rent to the amount that excludes the energy cost, until the approved benefit is depleted. Once the approved benefit amount is depleted, the tenant's regular rental amount that includes the energy cost will be reinstated. If for any reason the tenant moves or is evicted before the funds are depleted, the remaining portion will be returned to the tenant. If the tenant cannot be located, any remaining LIHEAP balance will be remitted to the Tennessee Department of Treasury under the tenant's name.

Approved By Landlord: _____ Date: _____

Approved By Tenant: _____ Date: _____