



**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

FOR AGENCY USE ONLY				REGISTER NUMBER(S)			
APPLICATION DATE		REGULAR ASSISTANCE		APPLICATION TIME		CRISIS INTERVENTION	
a.m.		p.m.		DISPOSITION TIME LIMIT		CARES ACT	
<input type="checkbox"/> 18 HOURS		<input type="checkbox"/> 72 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.**
- **Do not use white-out; cross-outs/strikethroughs are accepted.**

**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 utility do you need assistance with?**

Gas     Electricity     Propane     Other \_\_\_\_\_

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

Last Name		First Name		Middle Name	
Mailing Address		City	State	Zip Code	
Street or Service Address ( <b>MUST BE LISTED</b> )		City	State	Zip Code	
Social Security Number	Phone Number	County of Residence	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	
Age	Do you have a Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	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"/> American Indian 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.								
7.								

**● 3. HOUSEHOLD INCOME**

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

WHO IS EMPLOYED	HOW OFTEN PAID	GROSS AMOUNT LAST MONTH	EMPLOYER NAME	YOU MUST ATTACH COPIES OF LAST MONTH'S PAY STUBS
1.				
2.				
3.				

B. **EMPLOYMENT** – When were you or any member of your household age 18 or older last employed? **NOTE:** If you are no longer employed, or have not worked in the past 6 - 12 months; Please provide documentation that unemployment benefits are not being received.

NAME	WHERE	WHEN
1.		
2.		

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

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 (please describe):

WHO RECEIVES IT?	HOW OFTEN PAID	GROSS MONTHLY AMOUNT	NON-WORK INCOME FROM (SSA, RETIREMENT, ETC.)	YOU MUST ATTACH DOCUMENTATION FOR ALL NON-WORK INCOME
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					
CD					
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 week's 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**, please attach a copy of your lease that indicates utilities are included in your rent and provide the **name and phone number** of your Landlord.

\_\_\_\_\_ LANDLORD'S NAME      \_\_\_\_\_ LANDLORD'S PHONE

Check (✓) the **primary** or **main** fuel used to heat (not light) your residence **CHECK ONLY ONE.**

- Natural Gas       Electricity       Fuel oil or kerosene       Propane, Butane, LP, or PPG (in a bottle or tank)       Wood or Coal

Check (✓) the **secondary** or **other** fuel used to heat (not light) your residence **CHECK ONLY ONE.**

- Natural Gas       Electricity       Fuel oil or kerosene       Propane, Butane, LP, or PPG (in a bottle or tank)       Wood or Coal      N/A

● **5. HOME ENERGY SUPPLIER INFORMATION**

Complete the following Section to show your Energy Suppliers (gas, electric, propane, etc.)

You must complete information on **BOTH - GAS AND ELECTRIC** AND include copies of **EACH** bill.

My residence is ALL ELECTRIC  YES  NO

List Name of Gas, Propane, or Wood Supplier: \_\_\_\_\_ Account Number: \_\_\_\_\_

Is the account closed?  YES  NO

Annual Propane Cost: \$ \_\_\_\_\_ (Previous heating cost 12 Months prior to the date of Application).

If your heating bill is **not** in your name, whose name is the account in? \_\_\_\_\_

Does this person live with you?  YES  NO

List 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

● **6. VERIFICATION OF IDENTITY**

LIHEAP Policy requires applicants for HEAP to provide additional documents with each LIHEAP application.

A **READABLE COPY** of one of the following VALID identifications must be provided.

- 1. Arkansas Driver's License
- 2. Birth Certificate or similar document
- 3. Work or school identification card
- 4. Identification card for health benefits or other assistance
- 5. Voter registration card
- 6. Pay check stubs containing the name of the person

Any document that reasonably establishes the applicant or authorized representative's identity will be accepted.

● **7. WEATHERIZATION SERVICES (WAP) NOTE: This is not an application for Weatherization services.**

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

Are you interested in the Air Conditioning Program?  YES  NO

● **8. APPLICANTS RIGHTS AND RESPONSIBILITIES**

PLEASE BE SURE THAT YOU HAVE SIGNED YOUR NAME IN THE SPACE PROVIDED BELOW FOR SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE. **FAILURE TO SIGN AND DATE THE 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 authorized by you.

I declare that all members of my household are legal residents of the United States.

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

# FOR AGENCY USE ONLY

## 1. CRISIS SITUATION: Verification must be attached

- Past due balance on bill
- Notice of imminent disconnection
- Disconnected                       Eviction Notice
- 10% or less of tank capacity and supplier refused delivery
- Other (specify) \_\_\_\_\_

### MINIMUM AMOUNT REQUIRED

- a. Past due for energy            \$ \_\_\_\_\_
- b. Connection fee                    \$ \_\_\_\_\_
- c. Reconnection fee                \$ \_\_\_\_\_
- d. Deposit                                \$ \_\_\_\_\_
- e. Minimum delivery                \$ \_\_\_\_\_
- f. Tank rental                            \$ \_\_\_\_\_
- g. Other (specify)                    \$ \_\_\_\_\_
- h. Total amount needed            \$ \_\_\_\_\_

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_

DATE: \_\_\_\_\_ HH SIZE: \_\_\_\_\_  
 WORKER: \_\_\_\_\_

- A. BUDGET:** 1. Income Month \_\_\_\_\_  
 Month of Application  
 Month prior to application

- 2. **Total GROSS: (Earned Income)** \$ \_\_\_\_\_
- 3. **NET (Earned Income) 80% Gross** \$ \_\_\_\_\_
- 4. **Unearned Income**
  - Social Security                      \$ \_\_\_\_\_
  - Supplemental Security Income (SSI) \$ \_\_\_\_\_
  - Trans. Employment Asst. (TEA)    \$ \_\_\_\_\_
  - Veterans Affairs (V A) Benefits    \$ \_\_\_\_\_
  - Other                                      \$ \_\_\_\_\_
- 5. **Total Unearned Income** \$ \_\_\_\_\_
- 6. **Monthly Countable Income (3 & 5)** \$ \_\_\_\_\_

## 2. CIP BENEFIT COMPUTATION:

- a. Minimum amount necessary to alleviate crisis situation? \$ \_\_\_\_\_
- b. Amount of Regular Assistance Available? \$ \_\_\_\_\_
- c. Net amount necessary? \$ \_\_\_\_\_
- d. CIP available? \$ \_\_\_\_\_
- e. CARES Act Available? \$ \_\_\_\_\_
- f. Additional amount necessary \$ \_\_\_\_\_
- g. If f. is more than \$0, explain how the household or other source will furnish the additional amount necessary.

## B. DISPOSITION      Regular    Crisis    CARES

- 1. Previous Application  YES  NO    Register # \_\_\_\_\_
- 2.  Confirmed that the household has not been approved for Regular or Crisis program.
- 3.  Approved       Denial       Withdrawn
- 4. Disposition Date:  
     Regular: \_\_\_\_\_ CIP \_\_\_\_\_ CARES \_\_\_\_\_
- 5. Benefit Amount:  
     Regular: \_\_\_\_\_ CIP \_\_\_\_\_ CARES \_\_\_\_\_

## C. PAYMENT      Regular    Crisis    CARES

- 1. **Payee Supplier** \_\_\_\_\_  
     Supplier \_\_\_\_\_  
     Supplier \_\_\_\_\_  
     Applicant \_\_\_\_\_
- 2. **Assistance provided (Crisis only)**  
 Payment     Verbal Obligation     Specify  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Date: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.     p.m.
- 3. **Payment Date:** \_\_\_\_\_ Check #: \_\_\_\_\_
- 4. **Payment Date:** \_\_\_\_\_ Check #: \_\_\_\_\_
- 5. **Payment Date:** \_\_\_\_\_ Check #: \_\_\_\_\_
- 6. **Service Restored**     YES     NO
- 7. **Loss of Service Prevented**     YES     NO

## D. WEATHERIZATION REFERRAL

Application was referred:  YES  NO  
 If no, why? \_\_\_\_\_

Applicant is an Agency Employee or Family Member?     YES     NO

Executive Directors' Signature: \_\_\_\_\_