

60% OF THE STATE MEDIAN INCOME GUIDELINES

UTILITY ASSISTANCE (Income Qualification Chart)

To qualify for assistance the monthly household income for your family size must be at or below the amount listed in the chart.

Family Size	Annually	Monthly
1	\$28,141	\$2,345.08
2	\$36,800	\$3,066.67
3	\$45,459	\$3,788.25
4	\$54,118	\$4,509.83
5	\$62,776	\$5,231.33
6	\$71,435	\$5,952.92
7	\$80,094	\$6,674.50
8	\$88,753	\$7,396.08
*For Each Additional Person Add:	\$8,659.00	\$721.58



COMMUNITY
SERVICES AGENCY

SHELBY COUNTY COMMUNITY SERVICES AGENCY
LOW INCOME HOME ENERGY ASSISTANCE
PROGRAM (LIHEAP)

REQUIRED DOCUMENTATION

SOCIAL SECURITY CARDS FOR EACH HOUSEHOLD MEMBER
BIRTH CERTIFICATE FOR CHILDREN 5 YEARS OLD OR YOUNGER
VALID GOVERNMENT ISSUED IDENTIFICATION
PROOF OF ALL HOUSEHOLD INCOME FOR THE LAST 30 DAYS FOR ALL **MEMBERS OVER THE AGE OF 18**
PROOF OF VETERAN STATUS
COPY OF MOST RECENT UTILITY BILL OR RECEIPT FROM FUEL SOURCE
PERMISSION TO APPLY STATEMENT (*IF UTILITIES ARE NOT IN THE APPLICANTS NAME*)
LIHEAP EARNED INCOME VERIFICATION

REQUIRED DOCUMENTATION OF INCOME

SOCIAL SECURITY, SSI, PENSION, DISABILITY AND VA BENEFITS

CURRENT AWARD LETTER
CURRENT PRINTOUT FROM SOCIAL SECURITY ADMINISTRATION OFFICE

TANF/AFDC INCOME

CURRENT DISPOSITION PRINTOUT FROM DEPARTMENT OF HUMAN SERVICES
CURRENT LETTER STATING ELIGIBILITY RECEIVED BY MAIL. THE LETTER SHOULD INCLUDE A BENEFIT AMOUNT.

CHILD SUPPORT

CURRENT PRINTOUT FROM JUVENILE COURT WITH THE GROSS AMOUNT COLLECTED
MONTHLY CURRENT OUT OF STATE CHILD SUPPORT- LEGAL COURT DOCUMENT WITH STATE SEAL

UNEMPLOYMENT BENEFITS

CURRENT PRINTOUT FROM STATE OF TENNESSEE (CLAIM SUMMARY), INCLUDING STATES OUTSIDE OF TENNESSEE

EMPLOYMENT

CHECK STUBS FROM EMPLOYER - **IN ORDER BY DATE RECEIVED**
▶ **LAST 30 DAYS OF PAY**
CURRENT LETTER VERIFYING GROSS WAGES (PAY RATE, HOURS WORKED PER WEEK, PAY DATE)
▶ MUST BE SIGNED AND DATED
▶ MUST BE ON 8 ½ X 11 COMPANY LETTERHEAD

ZERO INCOME

COMPLETE SELF-DECLARATION OF ZERO INCOME FORM-ALL MEMBERS 18 YEARS OF AGE AND OLDER (PROVIDED UPON REQUEST)

SELF EMPLOYED

CURRENT/PRIOR YEAR TAX RETURN
SELF-EMPLOYMENT FORM (PROVIDED UPON REQUEST)

SHELBY COUNTY SCHOOL EMPLOYEE

STATEMENT STATING GROSS AMOUNT, HIRE DATE, HOURS WORKED PER WEEK, PAY DATE AND EITHER 9, 10 OR 12 MONTH EMPLOYEE **OR** CURRENT CHECK STUB FOR LAST 30 DAYS.



LOW INCOME HOME ENERGY ASSISTANCE ASSISTANCE PROGRAM (LIHEAP) APPLICATION FOR ASSISTANCE

*Application is not complete without applicant signature on page 2

Date Application Received: _____

Type of assistance you are applying for: (Check one)

Energy Assistance Crisis Assistance

Have you received assistance under LIHEAP since October 1, 2023 through any TN Agency? Yes No

If yes, which agency provided assistance? _____

Applicant Name: _____ Telephone: _____

Cell: _____ Permission to Text? Y N

Current Address: _____ City: _____ State: _____ Zip: _____

Applicant Email: _____ County: _____

Mailing Address (if different from Current Address): _____ City: _____ State: _____ Zip: _____

LIST ALL HOUSEHOLD MEMBERS (INCLUDING APPLICANT). USE ADDITIONAL PAPER IF YOU NEED MORE SPACE)

NAME (must provide first and last name)	Marital Status	Relation to Applicant	Social Security Number	Date of Birth	Age	Sex	Race (optional)	Highest Grade Completed	Vet or Active Military	Assistance for Disability?	Health Insurance	Income	Type of Income or Assistance
		Applicant							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	
									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	

Family Type: Please check one:

Single Individual

Female Single Parent

Male Single Parent

Adult(s) with Child(ren)

Adult(s) without Child(ren)

Other

SELF DECLARATION OF DISABILITY (Please use additional paper if more space is needed)

NAME OF HOUSEHOLD MEMBER AND PLEASE STATE PERMANENT DISABILITY: _____

DOES HOUSEHOLD MEMBER HAVE A SIGNED MEDICAL STATEMENT THAT REQUIRES LIFE SUPPORT EQUIPMENT? YES NO (circle)

NAME OF HOUSEHOLD MEMBER AND PLEASE STATE PERMANENT DISABILITY: _____

DOES HOUSEHOLD MEMBER HAVE A SIGNED MEDICAL STATEMENT THAT REQUIRES LIFE SUPPORT EQUIPMENT? YES NO (circle)

NAME OF HOUSEHOLD MEMBER AND PLEASE STATE PERMANENT DISABILITY: _____

DOES HOUSEHOLD MEMBER HAVE A SIGNED MEDICAL STATEMENT THAT REQUIRES LIFE SUPPORT EQUIPMENT? YES NO (circle)

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

HOUSEHOLD TOTAL INCOME List income information for applicant and all household members. Use additional paper if more space is needed. Wages are only listed for household members 18 or older.

HOUSEHOLD MEMBER NAME	SOURCE OF INCOME	GROSS MONTHLY INCOME	IF WAGES, HOW OFTEN PAID AND EMPLOYMENT START DATE

◆◆◆ YOU MUST ATTACH CURRENT INCOME DOCUMENTATION FOR EVERY PERSON IN THE HOUSEHOLD ◆◆◆

HOUSING (Please check one) **OWN** **RENT** **SECTION 8** **PUBLIC HOUSING AUTHORITY** If Utilities are in Public Housing or Section 8 name, Amount of Utility "Overage" \$ _____

UTILITY COMPANY TO RECEIVE PAYMENT: (YOUR FIRST CHOICE)

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 it's payments.

UTILITY COMPANY TO RECEIVE PAYMENT: (SECOND CHOICE)

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 it's payments.

***** PLEASE ATTACH ANNUAL ENERGY USAGE DOCUMENTATION *****

Has your home ever been served under our Weatherization Assistance Program? Yes No

Are you interested in learning more about the Weatherization Program? Yes No

APPLYING FOR "CRISIS" ASSISTANCE? *Let's see if you qualify*

Do you have a utility disconnect notice, or are you past due? Y or N

Do you have less than \$25 on a pre-paid utility account? Y or N

If Y to either question, be sure to attach documentation.

In addition you must meet one of the following criteria:

Do you have a household member 60 or older, or below 6?

Do you have a household member with a disability?

Do you have a household member that is a veteran or active military?

Is your household is experiencing a qualifying uncontrollable circumstance?

Please contact your local agency to discuss.

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 U.S.C. § 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. 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 NOT BE SHARED WITH ANY OTHER PERSONS OR AGENCIES EXCEPT FOR PURPOSES DIRECTLY RELATED TO THE ADMINISTRATION OF THE PROGRAM (LIHEAP). 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. I DO OR DO NOT AGREE THAT THE INFORMATION CONTAINED IN MY APPLICATION MAY BE SHARED WITH OTHER AGENCIES FROM WHICH I SEEK ADDITIONAL SERVICES.

APPLICANT SIGNATURE: _____ DATE: _____

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 the LIHEAP program.

To Be Completed By Agency Staff Only:

SIGNATURE OF DETERMINING AGENCY OFFICIAL: _____ DATE CERTIFIED: _____

SHELBY COUNTY COMMUNITY SERVICES AGENCY

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

TITLE VI ACKNOWLEDGEMENT

Assures "Nondiscrimination in Federally Assisted Programs"

"NO PERSON IN THE UNITED STATES SHALL, ON THE GROUNDS OF RACE, COLOR, OR ORIGIN WILL BE EXCLUDED FROM PARTICIPATION IN, BE DENIED THE BENEFITS OF, OR BE SUBJECT TO DISCRIMINATION UNDER ANY PROGRAM OR ACTIVITY RECEIVING FEDERAL FINANCIAL ASSISTANCE"

Prohibited practices include but are not limited to:

- Denying a person any services, financial aid, or other benefits because of race, color, or national origin.
- Providing different services or benefits, or providing these in a different manner from those provided to others in the program.
- Requiring different standards or conditions as prerequisites for serving individuals.
- Locating facilities in any way that would limit or impede access to federally funded services or benefits.
- Failing to make allowances for language or educational difficulties.

Any person(s) or organization(s) believing they have been a victim of discrimination based on race, color, or national origin, may file a complaint with the agency in question or with the Shelby County Title VI Coordinator.

RELEASE OF INFORMATION

This is to confirm that I do hereby give permission to Shelby County Community Services Agency to share and/or secure any information necessary to certify me for the **Low Income Home Energy Assistance Program**. I understand that this information will only be shared, secured, or verified professionally while protecting my rights to confidentiality. I also do hereby grant Shelby County Community Services Agency permission to secure additional resources on my behalf, if necessary and appropriate. I do request, however, that _____ not be contacted.

GRIEVANCE PROCEDURE

Clients applying for assistance through all programs offered by the Shelby County Community Services Agency have the right to appeal any decision made on their behalf, except when funds have been depleted.

Clients have the right to appeal and request a fair hearing. Client must contact Shelby County Community Services Agency for the proper complaint form. After a decision has been made, a complaint form must be filled out in triplicates and completed within (30) days. The Client, the Agency, and the State will retain a copy of the complaint form.

X _____

Client Signature

X _____

Date



SHELBY COUNTY COMMUNITY SERVICES AGENCY

PERMISSION TO APPLY STATEMENT

Please complete this form if the Applicant's Utility Services are in someone else's name.

If the person whose name is on the utility bill is currently living, please have them complete the following portion in its entirety.

I, _____, do hereby give _____
(Name of person on Utility Bill) (Applicant's Name)

Permission to apply for Utility Assistance at the following address:

(Street Name) (City/State) (Zip Code)

I, _____, do not reside in the same household as _____
(Name of person on Utility Bill) (Applicant's Name)

My current address is:

(Street name) (City/State) (Zip code)

(Signature) (Date) (Contact Number)

If the person whose name is on the Utility bill is deceased : The Applicant must complete the following portion, attach proof of residency and proof of death.

I, _____, do hereby declare that _____
(Applicant's Name) (Name of Person on Utility Bill)

Is deceased and I am financially responsible for the Utility Services at the following address:

(Street Name) (City/State) (Zip Code)

(Signature) (Date)



Shelby County Community Services

Mail completed applications to 1188 Minna Pl., Memphis, TN 38104



SELF-DECLARATION OF ZERO INCOME

(To be completed by the applicant)

Purpose: Only after all avenues of documenting zero income have been exhausted, a signed Self-Declaration of Zero Income is permissible to use. The Applicant must fill out and sign this form in its entirety, listing all adult household members declaring zero income within the last 30 days.

Applicant Name: _____

Primary Address: _____

I do hereby certify members listed on this form **have not** received income from the following resources within the last 30 days:

- Wages, salaries, tips before any deductions:
- Net receipts from non-farm or farm self-employment (receipts from a person’s own business or from an owned or rented farm after deductions for business or farm expenses)
- Regular payments from social security, TANF, railroad retirement, unemployment compensation, strike benefits from union funds, workers compensation, veteran’s payments, training stipends, alimony, child support, regular adoption assistance, and military family allotments or regular support from an absent family member or someone not living in the household
- Private pensions, government employee pensions (including military retirement pay), and regular insurance or annuity payments
- Net college or university scholarships, grants, fellowships or assistantships
- Dividends and/or interest
- Net rental income and net royalties
- Periodic receipts from estates or trusts; and
- Net gambling or lottery winnings
- Black Lung benefits will be considered income except for the first \$20 of each monthly benefit.

Note: Please list below all household members eighteen (18) years an older self-declaring zero income.

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

I certify that the information above is correct. Falsifying and/or withholding income information is a federal offense and I can be convicted to a fine of \$10,000 or imprisonment for no more than five years or both under the state of Tennessee Laws.

Signature of Applicant: _____

Date: _____