

LIEAP (Low Income Energy Assistance Program)

ENERGY PROGRAM MAIL-IN APPLICATION

**LIEAP
APPLICATION
CHECKLIST**

Please make sure you complete the following items:

- Fill out application completely, including all highlighted areas and signatures
- Provide proof of income
- Provide bank account information, including any savings for proof of resources
- Make sure you have included a valid phone number where you can be reached for a phone interview

Once all paperwork has been completed, please mail the LIEAP application to:

Rutherford County DSS
Attn: LIEAP
PO Box 242
Spindale, NC 28160

Or drop the application off at:

Rutherford County DSS
Building A
389 Fairground Road
Spindale, NC 28160

Once the application is received at DSS, you will be contacted within 48 hours for your phone interview to complete your application. If there is any required information missing you will be sent a letter and given ten (10) business days to return needed information. If you have any questions, comments or concerns please call DSS at (828) 288-4022, (828) 287-6328 or (828) 287-6165.

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Date: _____

Applicant Name: _____ **Phone:** _____
First MI Last

Address: _____

Mailing Address (IF Different): _____

Sex: M F **Race:** Black White Indian Asian Other: _____
(Circle One) (Circle One)

Ethnicity: Not Hispanic/Latino _____ Hispanic Cuban _____ Hispanic Other _____
 Hispanic Puerto Rican _____ Unreported _____

Language: _____

LIST BELOW EVERYONE WHO LIVES AT THE ABOVE ADDRESS (including applicant)

Household Member	DOB	SS #	Relationship to Applicant	Sex	US Citizen or Eligible Alien
1.				M F	
2.				M F	
3.				M F	
4.				M F	
5.				M F	
6.				M F	

Is anyone in your household (circle all that apply):	Elderly (60+)	Disabled	Disabled – Receiving Services thru DAAS
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How do you heat your home? (PRIMARY HEATING SOURCE – Please circle one):

What is your primary heating source - what you use most often: Fuel type given at time of application will not be changed even if you later change your primary source.

Natural Gas Electricity Kerosene Fuel Oil LP Gas Wood Coal

DOES ANYONE IN THE HOME RECEIVE THE FOLLOWING?

WFFA \$ _____	SSI \$ _____
SOCIAL SECURITY \$ _____	WORKER'S COMP \$ _____
UNEMPLOYMENT \$ _____	CHILD SUPPORT \$ _____
CONTRIBUTIONS \$ _____	WORK RELEASE \$ _____
RETIREMENT \$ _____	STOCKS, BONDS \$ _____

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DOES ANYONE IN THE HOME HAVE ANY OF THE FOLLOWING?

CHECKING ACCOUNT \$ _____

SAVINGS ACCOUNT \$ _____

REAL ESTATE \$ _____

TRUST FUNDS, STOCKS \$ _____

CASH ON HAND \$ _____

OTHER \$ _____

Household Member	Source of Income	Income Amount	Resources (Assets)
1.			
2.			
3.			
4.			
5.			
6.			

CIVIL RIGHTS

No person in the United States shall, on the grounds of race, color, national origin, age, sex, disability, handicap, political beliefs, or religion, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this program.

I understand that it is against the law for me to make false statements and that I am subject to prosecution if I do. I certify that the information I have provided is a true and complete statement of facts according to my best knowledge and belief. I give the agency permission to verify any information necessary to determine my eligibility for the LIEAP Program. I understand that the information on this form may be checked by the State or Federal reviewer and I agree to this review.

***Signature/Applicant**

Witness

Date

Signature/Worker

Authorized Representative

Date

Telephone Interview Notes (For Agency Use Only):

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Signature: _____

Date: _____

I affirm the above information is true and accurate. I also give Rutherford County Department of Social Services permission to discuss my situation with my collateral contacts or any business or individuals they deem appropriate.

The Department of Social Services administers the Food and Nutrition Program, Medicaid, Work First Family Assistance (WFFA) as well as other financial and social services. I understand it is my right to apply for any of these programs today without delay.

Signature: _____

Date: _____

NOTE: The fiscal year for Crisis Intervention Program (CIP) runs from July 1 to June 30 each year. We do not pay any OLD BILLS, DEPOSITS, LATE FEES OR RECONNECT FEES.

OFFER OF MEDICAL ASSISTANCE

Do the children in your home receive medical assistance? Yes No

If not, would you like to apply? Yes No

If you want to apply, would you like to:

See a caseworker today to make an application Yes No

Make an appointment and return to complete the application if you are unable to stay? Yes No

Complete a mail-in application, if applicable? Yes No

Do you or your spouse receive medical assistance? Yes No

If not, would you like to apply? Yes No

If you want to apply, would you like to:

See a caseworker today to make an application Yes No

Make an appointment and return to complete the application if you are unable to stay? Yes No

Complete a mail-in application, if applicable? Yes No

I understand that if I choose to apply by mail, the date of application is the date that the completed application form is returned to the agency. I also understand that I may apply/reapply for medical assistance at any time.

_____ I decline the right to apply for medical assistance today and I understand the loss of potential benefits by not making an application today.

Client Signature

Worker Signature