



Low- Income Home Energy Assistance (LIHEAP) Program Application

Low- Income Household Water Assistance (LIHWAP) Program Application

Documentation Needed:

- A valid picture of identification for the head of the household
- Social Security cards for every household member
- Proof of income for every household member. Household reporting zero income must provide additional documentation.
- A disconnect notice or current bill (within the last 30 days) from utility (**water or energy**) company.
- Another current household bill or document showing name and address of applicant

If all required documents are not received, your application will be determined incomplete; as we cannot process an application without all of the required documents. You will need to reapply.

Applicant Information: **LIHEAP Program (Energy Assistance)** **LIHWAP Program (Water Assistance)**

First name(required)		Last name(required)	
Gender(required) <input type="checkbox"/> Female <input type="checkbox"/> Trans Female (MTF) <input type="checkbox"/> Male <input type="checkbox"/> Trans Male (FTM)		Date of Birth(required)	SSN(required)
Race(required) <input type="checkbox"/> Black, African American <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Other _____		Primary Language(required) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Other _____	Citizen(required) <input type="checkbox"/> Yes <input type="checkbox"/> No
Ethnicity(required) <input type="checkbox"/> Hispanic, Latino or Spanish Origins <input type="checkbox"/> Not Hispanic, Latino or Spanish Origins			Veteran(required) <input type="checkbox"/> Yes <input type="checkbox"/> No
Street address(This is where you receive energy/water service) (required)		Apartment/Unit(if applicable)	
City(required)		State(required)	Zip code(required)
Phone Number(one # required) <input type="checkbox"/> Mobile _____ <input type="checkbox"/> Home _____		Email Address(optional)	
Disability(required)	Marital Status(required)	Employed(required)	Housing(required)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Single <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Own
Health Insurance(required)	Education Level(required)		
<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private <input type="checkbox"/> No Insurance	<input type="checkbox"/> Grade 0 -8 <input type="checkbox"/> Grades 9 – 12/Non-Graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> GED/Equivalency	<input type="checkbox"/> 12 Grade + Some Post-Secondary <input type="checkbox"/> 2 or 4 years College Graduate <input type="checkbox"/> Graduate or other post-secondary <input type="checkbox"/> Unknown	

Additional Household Members

(1) First name (required)		Last name (required)			
Gender (required) <input type="checkbox"/> Female <input type="checkbox"/> Trans Female (MTF) <input type="checkbox"/> Male <input type="checkbox"/> Trans Male (FTM)		Date of Birth (required)		SSN (required)	
Relationship to HOH (required) <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild <input type="checkbox"/> Guardian <input type="checkbox"/> Foster child <input type="checkbox"/> Other Relative _____					
Race (required) <input type="checkbox"/> Black, African American <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Other _____		Primary Language (required) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Other _____		Citizen (required) <input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> Veteran (required) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ethnicity (required) <input type="checkbox"/> Hispanic, Latino or Spanish Origins <input type="checkbox"/> Not Hispanic, Latino or Spanish Origins					
Disability (required)		Marital Status (required)		Employed (required)	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Single <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				Housing (required)	
				<input type="checkbox"/> Rent <input type="checkbox"/> Own	
Health Insurance (required)		Education Level (required)			
<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private <input type="checkbox"/> No Insurance		<input type="checkbox"/> Grade 0 -8 <input type="checkbox"/> 12 Grade + Some Post-Secondary <input type="checkbox"/> Grades 9 – 12/Non-Graduate <input type="checkbox"/> 2 or 4 years College Graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> Graduate or other post-secondary <input type="checkbox"/> GED/Equivalency <input type="checkbox"/> Unknown			
(2) First name (required)		Last name (required)			
Gender (required) <input type="checkbox"/> Female <input type="checkbox"/> Trans Female (MTF) <input type="checkbox"/> Male <input type="checkbox"/> Trans Male (FTM)		Date of Birth (required)		SSN (required)	
Relationship to HOH (required) <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild <input type="checkbox"/> Guardian <input type="checkbox"/> Foster child <input type="checkbox"/> Other Relative _____					
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Ethnicity (required) <input type="checkbox"/> Hispanic, Latino or Spanish Origins <input type="checkbox"/> Not Hispanic, Latino or Spanish Origins					
Disability (required)		Marital Status (required)		Employed (required)	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Single <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				Housing (required)	
				<input type="checkbox"/> Rent <input type="checkbox"/> Own	
Health Insurance (required)		Education Level (required)			
<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private <input type="checkbox"/> No Insurance		<input type="checkbox"/> Grade 0 -8 <input type="checkbox"/> 12 Grade + Some Post-Secondary <input type="checkbox"/> Grades 9 – 12/Non-Graduate <input type="checkbox"/> 2 or 4 years College Graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> Graduate or other post-secondary <input type="checkbox"/> GED/Equivalency <input type="checkbox"/> Unknown			

Additional Household Members

(3) First name(required)		Last name(required)			
Gender(required) <input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Trans Female (MTF) <input type="checkbox"/> Trans Male (FTM)		Date of Birth(required)	SSN(required)
Relationship to HOH(required) <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild <input type="checkbox"/> Guardian <input type="checkbox"/> Foster child <input type="checkbox"/> Other Relative _____					
Race(required) <input type="checkbox"/> Black, African American <input type="checkbox"/> White <input type="checkbox"/> Other _____		<input type="checkbox"/> Asian or Asian American <input type="checkbox"/> American Indian		Primary Language(required) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Other _____	
Ethnicity(required) <input type="checkbox"/> Hispanic, Latino or Spanish Origins <input type="checkbox"/> Not Hispanic, Latino or Spanish Origins				Citizen(required) <input type="checkbox"/> Yes <input type="checkbox"/> No Veteran(required) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Disability(required) <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status(required) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		<input type="checkbox"/> Widow/Widower <input type="checkbox"/> Never Married	Employed(required) <input type="checkbox"/> Yes <input type="checkbox"/> No	Housing(required) <input type="checkbox"/> Rent <input type="checkbox"/> Own
Health Insurance(required) <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private <input type="checkbox"/> No Insurance		Education Level(required) <input type="checkbox"/> Grade 0 -8 <input type="checkbox"/> Grades 9 – 12/Non-Graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> GED/Equivalency			
				<input type="checkbox"/> 12 Grade + Some Post-Secondary <input type="checkbox"/> 2 or 4 years College Graduate <input type="checkbox"/> Graduate or other post-secondary <input type="checkbox"/> Unknown	
(4) First name(required)		Last name(required)			
Gender(required) <input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Trans Female (MTF) <input type="checkbox"/> Trans Male (FTM)		Date of Birth(required)	SSN(required)
Relationship to HOH(required) <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild <input type="checkbox"/> Guardian <input type="checkbox"/> Foster child <input type="checkbox"/> Other Relative _____					
Race(required) <input type="checkbox"/> Black, African American <input type="checkbox"/> White <input type="checkbox"/> Other _____		<input type="checkbox"/> Asian or Asian American <input type="checkbox"/> American Indian		Primary Language(required) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Other _____	
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Disability(required) <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status(required) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		<input type="checkbox"/> Widow/Widower <input type="checkbox"/> Never Married	Employed(required) <input type="checkbox"/> Yes <input type="checkbox"/> No	Housing(required) <input type="checkbox"/> Rent <input type="checkbox"/> Own
Health Insurance(required) <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private <input type="checkbox"/> No Insurance		Education Level(required) <input type="checkbox"/> Grade 0 -8 <input type="checkbox"/> Grades 9 – 12/Non-Graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> GED/Equivalency			
				<input type="checkbox"/> 12 Grade + Some Post-Secondary <input type="checkbox"/> 2 or 4 years College Graduate <input type="checkbox"/> Graduate or other post-secondary <input type="checkbox"/> Unknown	

HOUSEHOLD INCOME:

Please check each box in the table below for all sources of household income.

Attach/submit proof of all household income for each household member such as a pay stub, Social Security letter, child support letter, unemployment letter, self-employment documentation, etc.

Income Source	Check each source of household income for family members
Employment (wages/paystub)	<input type="checkbox"/>
Social Security (benefit letter)	<input type="checkbox"/>
Child Support (court order)	<input type="checkbox"/>
Alimony (court order)	<input type="checkbox"/>
Unemployment (benefit letter)	<input type="checkbox"/>
Pension	<input type="checkbox"/>
Workers compensation (benefit letter)	<input type="checkbox"/>
Self-Employment (tax return)	<input type="checkbox"/>
Zero Income (affidavit)	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>

Applicant Signature

I have read and understand the Consent on 'Income Information', 'Confidentiality Waiver', and 'Penalty Provision'. I understand and agree that Louisiana Housing and/or the CAA may contact any and all listed sources of income for verification as necessary, such as TANF, General Assistance etc.

Primary Applicant Signature

Family Service Worker

Date

Date

"AN EQUAL OPPORTUNITY EMPLOYER/PROGRAM"

"Auxiliary Aids and Services are available upon request to individuals with disabilities"

LA LIHEAP Assurance Statement

APPLICANT ASSURES THAT:

- * I have furnished true and correct information regarding household income and size and agree to promptly report any changes in the household income or number of individuals living at the listed address;
 - * I grant East Baton Rouge Parish/Office of Social Services and the LHC full permission to verify any and all information with both public and private sources or any entity, which may have furnished me utility services;
 - * I understand that if I receive services for which I am ineligible because of false information, I may be required to repay the LHC;
 - * I understand that I have a right to request a fair hearing from the LHC if I feel that the decision regarding services requested is unfair or that my civil rights have been violated. The contractor staff person completing this application has read these assurances to me; I fully understand this agreement and have been given an opportunity to ask questions;
 - * I understand that by signing this document that I attest to the truth of all information provided (either verbally or in writing) to the LHC;
 - * I certify that I live at the listed address and am responsible for payment of utility bills at that address.
 - * I certify the listed address is my primary place of residence.
- []Yes []No

Applicant's Signature _____

Date _____

Authorization to Release Information

APPLICANT AUTHORIZES LHC TO RELEASE INFORMATION

- * I understand that the personal information furnished by me to process my LIHEAP application for assistance is confidential information.
 - * I understand that providing authorization to release information is not required for me to obtain services under LIHEAP and is strictly voluntary.
 - * I understand and agree to the release of my energy expenditure data to others; that the collection of the data is for statistical research, referral evaluation and/or analysis; that I hold harmless the vendor(s) that supply the data to the grantee.
 - * I authorize Louisiana Housing Corporation(LHC) to release or disclose all or parts of the information in my client file to outside sources for the purposes stated above.
- []Yes []No

Applicant's Signature _____

Date _____

Right to an Appeal and Fair Hearing

If you believe that you have been treated unfairly or a mistake has been made about your eligibility for services; you have the right to request a fair hearing. This means that you will be given an appeal review and/or hearing by the LHC at which time you will be able to present your side for review by persons who will assure that you are treated fairly. Before you request a fair hearing, you or your representative may discuss your concerns with a worker or supervisor of the contractor agency for an explanation of the reason for the agency's action. If you are still dissatisfied, you may request a fair hearing within 30 days after the agency's decision by completing and signing below and mailing this form to Louisiana Housing Corporation - 11637 Industriplex Blvd. - Baton Rouge, LA 70807. You will be notified of the date and place of the fair hearing at which time you can represent yourself or authorize someone else such as legal counsel, relative or friend. I wish to request a fair hearing because.

Comment:

Applicant's Signature _____

Date _____

Civil Rights:

If you believe you have been discriminated against because of race, color, religion, gender, age, national origin, and/or handicapped condition, you may file a complaint either through the contractor agency or directly to Louisiana Housing Corporation - 11637 Industriplex Blvd. - Baton Rouge, LA 70807 or to the Louisiana Commission on Human Rights 695 N. 4th Street Suite 822 - Baton Rouge, LA 70802, or to the EEO Commission, New Orleans Field Office, 500 Poydras St., Suite 809 - New Orleans, LA 70130. By signing this application below, I acknowledge that I have read all of the above information, the certifications, and my rights as an applicant for services.

Applicant's Signature _____

Date _____

Worker's Signature _____

Date _____

In signing this form, the worker certifies that the above stated assurances: Authorization to Release Information, Right to Appeal, Fair Hearing Statement and Civil Rights Statement have been read and explained to the applicant.

CERTIFICATION FORM

For
Community Services Block Grant
Program Participants

ACKNOWLEDGING RECEIPT OF NOTICE ABOUT WHERE TO OBTAIN INFORMATION ON CSBG DISCRIMINATION COMPLAINT AND GRIEVANCE PROCEDURES.

I certify that I have been advised of my rights under Department of Health and Human Services' Regulations at 45 CFR 80, Title VI of the Civil Rights Act of 1964, and 45 CFR 84, Nondiscrimination on basis of handicap in Programs and Activities Receiving Federal Financial Assistance and understand these rights as they have been explained to me. Additionally, I have been provided a copy of the notice that includes information on where to file a CSBG discrimination complaint and/or grievance procedure.

PROGRAM(S) (CSBG FUNDED INDIRECTLY OR DIRECTLY)

Program Participant Name (Print)

Program Participant Signature

Date

"Equal Opportunity Employer/Program"
"Auxiliary Aids and Services are available upon request to individuals with disabilities"



Office of the Mayor-President

City of Baton Rouge
Parish of East Baton Rouge

Division of Human Development and Services

Office of Social Services
4523 Plank Road
Baton Rouge, Louisiana 70805

Vernadine Mabry, MPA
DHDS Director

Pamela Stokes
OSS Program Administrator

RELEASE OF INFORMATION FORM

Client Name: _____ Last 4 SSN # _____
(Please print)

I certify that the information I have provided is true and correct. I consent to the release of information contained in the spaces above, in the Caseworthy Computer system, or on the intake form used by this agency.

I allow the use of the information to be released within the Division of Human Development and Services, the Caseworthy Administrator, and the vendors as necessary to complete services for my household, to provide statistics on assistance provided, or as a safeguard against duplication of services.

I hereby authorize my fuel supplier or other vendors relate to my household to release information concerning my fuel or other accounts as necessary to insure timely processing of this application.

Yes No

This is to certify that I have received energy conservation education through counseling, and/or literature on ways to conserve energy by attending an Energy Forum and viewing an energy conservation video at the Office of Social Services with the City of Baton Rouge.

Yes No

This is to certify that I have received information on Support Enforcement Services regarding Child Support payments in an attempt to place responsibility for the support of the child/children on a non-custodial parent. This is an attempt to increase the emotional, financial, and medical support for the child/children.

Yes No

Applicant Signature: _____ Date: _____

Family Service Worker Signature: _____ Date: _____

“AN EQUAL OPPORTUNITY EMPLOYER/PROGRAM”
“Auxiliary Aids and Services are available upon request to individuals with disabilities”

