

PAPER APPLICATION

Illinois Low Income Home Energy Assistance Program (LIHEAP) / Illinois Home Weatherization Assistance Program (IHWAP)

To contact the Energy Assistance Hotline:

(Toll Free) (877) 411-9276

AppID#: _____

To report LIHEAP/IHWAP fraud or abuse:

Department of Commerce & Economic Opportunity

Office of Energy Assistance

Attn: Fraud Unit, 500 E. Monroe, Springfield, IL 62701

Agency: _____ Intake Site: _____

County: _____ PY: _____ Application Date: ___/___/___ Service Requested: _____ JOB#: _____

HOH	SSN	Name	Gen	Date of Birth	Eth	Eman	Dis	Vet	Wages	SSA	Unempl	SSI	TANF	GA	Oth
	***_**_			__/__/____											
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	***_**_			__/__/____											
Dwelling Type: SF 2-4 5-10 11+ MH GH SRO Rent: \$ _____										Totals:					
Shelter Own: Yes/No			SubH	SNAP	Veteran							Total Income: _____			

REFERRAL:						
Wx _____	Medicaid _____	SSI _____	Unemployment _____		Nutrition _____	Life Line _____
Safe place _____	Child care _____	Energy Cons. Tips _____	Budget _____		Aging _____	Other _____

ADDRESS:		Service Address: Street _____	
City: _____		Zip: _____ - ____	
Phone: (____) - ____ - ____ (Home, cell, neighbor, work, etc.)		Cell: (____) - ____ - ____ (Home, cell, neighbor, work, etc.)	
Phone2: (____) - ____ - ____ (Home, cell, neighbor, work, etc.)		E-Mail : _____ (E-Mail, neighbor, work, etc.)	
Mailing Address: Street _____			
City _____		Zip _____	

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VENDOR:			
Primary Vendor: _____	Secondary Vendor: _____	Prior Weatherization Date ___/___/___	LIHEAP Furnace Date ___/___/___
Client Pays: _____ Med Cert: _____	Client Pays: _____ Med Cert: _____	Re-Determination IHWAP ___/___/___	Documentation: Rec'd _____
COR: _____	COR: _____	Eligible Due to : 50%Rule _____	Rec'd Date _____
Fuel _____ Acct # _____	Fuel _____ Acct # _____	Eligible Due to :HTF _____	Eligible Due to : Income _____
Status _____	Status _____	Eligible Due to : LIHEAP _____	Household Income _____/___/___
Primary Energy Bill ___/___/___	Secondary Energy Bill ___/___/___	Eligible Due to : 66%Rule _____	Household SS#'s _____
		Eligible Due to : Auto _____	Home Ownership _____/___/___

SUPPLEMENTAL QUESTIONS
<ol style="list-style-type: none"> 1. Currently Have a Past Due Notice for Primary Vendor/Main Heating Fuel : (Required) 2. Supplemental Heating Fuel (Select one): 3. Main Cooling Equipment (Choose one): 4. Number of Sleeping Rooms in the Home: _____ 5. A/C Location (Choose one): 6. Number of Air Conditioner Units in the Home: _____

Please read and Sign:

IMPORTANT NOTICE: This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under the Low Income Home Energy Assistance Act of 1981 as amended. Disclosure of this information is REQUIRED. Failure to provide any information will result in this application not being processed. This application has been approved by the State Forms Management Center.

Applicant Statement: I certify that the information I have provided above is an accurate and complete disclosure of the requested information. I also certify that every household member in the application is either a US citizen or legal resident according to the LIHEAP/IHWAP rules. I authorize this agency to verify the information and contact my utility/fuel supplier, landlord, employer and/or other sources for verification or additional information and to exchange information contained in or otherwise used regarding my application and participation in LIHEAP/IHWAP. I also authorize DCEO and my utility/fuel supplier to share my usage and bill information during the twelve (12) month period prior to and after the date of my application submittal and/or completion of IHWAP services for the purpose of program evaluation and analysis. I have received information outlining my appeal rights.

I understand that filling out this application does not guarantee that my household will receive assistance. The purpose of this document is to provide a summary of the application to the client for future reference.

_____ Date ___/___/___		_____ Date ___/___/___
Signature of Applicant		Eligibility Verification /Determination Signature
_____ Date ___/___/___		_____ Date ___/___/___
Signature of Intake Worker		Payment Authorization Signature

I understand all income sources, for all household members, will be further verified by the State of Illinois. _____
Signature of Applicant Date