

**NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SOCIAL SERVICES
LOW INCOME ENERGY ASSISTANCE PROGRAM APPLICATION**

FORM ID
F

1 ENERGY NO.	2 FS NO.	3 FS DIST NO.	4 CO.RES. GEO ADM	5 CO. APP.	6 CO.CASE NO.	7 DIST NO.	8A SEX	8B RACE	8C ETH	8D LAN	9 DENIAL		
10 ADDRESS LINE 1			11 ADDRESS LINE 2			12 CITY		13 ST	14 ZIP CODE				
15 TOTAL EARNED INCOME	16 EARNED INC DEDUCTION	17 CHILD CARE	18 COUNTABLE EARNED INC	19 TOTAL UNEARNED INC		20 GROSS COUNTABLE INC		21 MEDICAL DEDUCTION	22 TOTAL COUNTABLE INC				
23 MIGRANT	24 NO. ELIG HH MEM	25 TOTAL HH MEM	26 RESERVE	27 VUL	28 FUEL TYPE	29 TRANSFER		30 NO. OF HH					
31 SSN	32 NAME FIRST MI LAST			33 DATE OF BIRTH	TYPE	34 MED DED	35 ERND INC	TYPE	36 PA/SSI	37 SS INC	38 OTH INC	39 REL	
	PAYEE												

I AGREE TO LET THE CASEWORKER KNOW OF ANY CHANGE IN ADDRESS WITHIN 5 CALENDAR DAYS. IT HAS BEEN EXPLAINED TO ME AND I UNDERSTAND THAT IT IS AGAINST THE LAW FOR ME TO MAKE FALSE STATEMENTS AND AS A RESULT RECEIVE BENEFITS FOR WHICH I AM NOT ELIGIBLE. I UNDERSTAND I AM SUBJECT TO PROSECUTION IF I DO. I CERTIFY THAT THE INFORMATION I HAVE PROVIDED ON THE APPLICATION FORM AND/OR QUESTIONNAIRE IS A TRUE AND COMPLETE STATEMENT OF FACTS ACCORDING TO MY BEST KNOWLEDGE AND BELIEF. I UNDERSTAND THAT THE INFORMATION ON THIS FORM MAY BE CHECKED BY STATE OR FEDERAL REVIEWER, AND I AGREE TO THIS REVIEW. I GIVE THE AGENCY PERMISSION TO VERIFY ANY UTILITY SUBSIDIES, INCOME, AND ASSETS NECESSARY TO DETERMINE MY ELIGIBILITY.

SIGNATURE OF CASEWORKER DATE SIGNED

SIGNATURE OF APPLICANT DATE SIGNED