



PO Box 1346
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BEFORE APPLICATION WILL BE PROCESSED
THE FOLLOWING DOCUMENTS MUST BE PROVIDED FOR
EACH HOUSEHOLD MEMBER:

1. **PROOF OF INCOME**
2. **SOCIAL SECURITY NUMBER**
3. **DATE OF BIRTH**
4. **ZERO INCOME STATEMENT (IF UNEMPLOYED)**
5. **HOME DEED/TITLE**
6. **LATEST ELECTRIC/GAS BILL**
7. **SIGN CONSENT FORMS**
8. **COPY OF DRIVERS LICENSE**

ERRP is an income-based program.

To be eligible for the program, you must first meet the income guidelines.

Additional requirements include:

- *Age 60+ or,**
- *Disabled (determined by the Social Security Administration) or,**
- *Housing a child 5 years or under**

Rental applications are not being accepted at this time.



West Virginia Department of Human Services APPLICATION FOR REPAIR OR REPLACEMENT

I. IDENTIFYING INFORMATION				B. Check any benefit being received by you or a member of your household: <input type="checkbox"/> SNAP Benefits <input type="checkbox"/> WV WORKS <input type="checkbox"/> Medicaid		
A. Name and Mailing Address of Applicant:				C. Directions to your home:		
Name						
Address						
City		County		D. Race (check one or more):		
State	Zip	Phone		<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> Asian		
If you do not have a telephone, please supply the name of a relative or neighbor who will take a message for you.				E. Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		
Name				If other race, please explain:		
Phone						
F. List the following information about yourself (Applicant) and ALL persons in your household. This includes family members and all others living under the same roof:						
G. Do you or anyone in your household need an accommodation because of a condition that would prevent you from completing the application process: (if yes, please explain)						

Full Name	Is this person a U.S. Citizen?	Birth Date mm/dd/yy	How is this person related to the Applicant?	Social Security Number	Total Monthly Income Before Deductions	
					Source or Name of Employer	Amount
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

II. INTAKE INFORMATION

Application date: _____
Name of worker taking application: _____
Case number: _____
County: _____

III. HOME HEATING INFORMATION

Instructions: Please check the correct box that applies to your household after each question and enter written statements where required.

A. What is your current living arrangement?

- ☐ House ☐ No shelter/homeless
☐ Apartment ☐ Mobile home
☐ Institution ☐ Other _____
(explain)

B. Do you own your home or rent?

- ☐ Own ☐ Rent

C. Is anyone in your household disabled or blind?

- ☐ Yes ☐ No

D. How do you heat your home?

(Check the item that corresponds to your primary source of home heating.)

PLEASE CHECK ONLY ONE.

- ☐ Natural gas furnace
☐ Liquefied gas (petroleum, propane, etc.)
☐ Coal
☐ Wood or wood products
☐ Electric furnace
☐ Fuel oil or kerosene furnace
☐ Baseboard heat
☐ Space heater (type)

E. Main Heating Source (same source as Question D)

Company/Vendor _____
Account # _____

Is your heating source included in your rent?

- ☐ Yes ☐ No

Has client applied for LIEAP?

- ☐ Yes ☐ No

Has client been approved for LIEAP?

- ☐ Yes ☐ No

F. Are you currently without a working heating unit?

- ☐ Yes ☐ No

G. Please describe the current issue with your heating unit.

H. Are you currently without a working cooling unit?

- ☐ Yes ☐ No

I. Have you had to make alternate living arrangements?

J. Approximate age of heating unit and/or cooling unit.

☐ Other

IV. SIGNATURES AND STATEMENTS OF LIABILITY			
<i>Place a check in the appropriate block with each statement.</i>			
<input type="checkbox"/> Yes <input type="checkbox"/> No	I understand I may request a hearing if I am not satisfied with any decision of the West Virginia Department of Human Services (DoHS) in determining my eligibility for Repair or Replacement or the amount of benefits approved, or if I feel that I have been discriminated against because of race, color, national origin, sex, age, religious or political beliefs, or because I am disabled; that I may be represented by an attorney at a fair hearing but that DoHS or any of its authorized representatives will not pay for these legal services; or that this intake will close without prior notice.	<input type="checkbox"/> Yes <input type="checkbox"/> No	I understand that I may be asked to provide additional information or verify any or all information entered on this application form and that I will cooperate by providing such information as required in determining my eligibility for Repair or Replacement; and I authorize DoHS to use and share all such information with other agencies, organizations, or entities to verify eligibility for the Repair or Replacement and the amount of benefits.
<input type="checkbox"/> Yes <input type="checkbox"/> No	I agree and authorize any bank, financial institution, governmental agency or department, corporation, business concern or person to furnish any information related to my eligibility for and receipt of the Repair or Replacement to DoHS or any of its authorized representatives and understand DoHS may use or share such information to verify my eligibility for and the amount of benefits.	<input type="checkbox"/> Yes <input type="checkbox"/> No	I understand that if I knowingly provide false or fraudulent information that is used in connection with the eligibility determination for Repair or Replacement, I may be subject, upon conviction, to fines or imprisonment or both. I understand I will be required to repay benefits received to which I am not entitled and that my failure to repay such benefits may result in loss of future Repair or Replacement benefits.
<input type="checkbox"/> Yes <input type="checkbox"/> No	I certify that I have read or had read to me all statements on this form and I do understand all questions. I further certify that all information given is true and correct to the best of my knowledge.	<input type="checkbox"/> Yes <input type="checkbox"/> No	I understand the date of application is the date I submit the completed form along with all required verifications and information, and that missing information may result in delay and/or denial of Repair or Replacement benefits.
<input type="checkbox"/> Yes <input type="checkbox"/> No	I give my consent for my heating and electric companies to give data about my account and energy usage to the DoHS, contractors for the LIEAP and the Weatherization Assistance Program.	<input type="checkbox"/> Yes <input type="checkbox"/> No	I understand that Repair or Replacement is a separate component of LIEAP and may close without notice due to funds being exhausted.
<input type="checkbox"/> Yes <input type="checkbox"/> No	I understand that in order to be eligible for the cooling repair or replacement that I have to meet the income guidelines and have someone in the household who is age 60 or older, disabled or have a child in the home that is age five (5) or younger. I also understand that I may be asked to provide verification of this prior to approval.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	I further understand that this program is separate from the Weatherization's Repair or Replacement Program. I give the Weatherization Assistance Program permission to contact me regarding Repair or Replacement on behalf of the DoHS.

MAIL THIS APPLICATION TO THIS ADDRESS AT THE BOTTOM OF THIS PAGE.

Your Signature			Date
Signature of Person Who Helped You Fill Out This Form			Date

This application cannot be processed unless all information requested has been entered or attached and it is signed and dated by you and the person who assisted you.

V. FOR DoHS USE ONLY (DFA LIEAP COORDINATOR TO COMPLETE)

A. Was application complete? ☐ Yes ☐ No

If no, what was missing? _____

Incomplete applications will be denied unless Applicant supplies missing information within 10 days or Worker is able to obtain the information within the 10-day period.

B. Date application received by DFA LIEAP Coordinator: _____

C. Date of Decision: _____
☐ Approved ☐ Heating ☐ Cooling
☐ Denied ☐ Heating ☐ Cooling

The date of application is the date the form is received by the local DoHS office.

D. Date referred to Weatherization: _____

Any additional comments:

LIEAP Coordinator's Signature		Date

You may scan all pages of this application and email it to dohsbcrepairreplace@wv.gov OR mail this application to the following address:
WV DoHS Bureau for Family Assistance
Attn: LIEAP Coordinator

**350 Capitol Street, Room B-18
Charleston, WV 25301**

Customer Consent Form

I, _____ give _____ (Community Action Agency) consent to release, obtain, store and share all pertinent identifying and non-personally identifying social, educational, medical, and other information about yourself or other members of your household that will allow you to benefit from services offered. In granting such permission, you understand that such information will be stored in a secure, electronic data management system. Your information will remain confidential and such information will only be used for your benefit or to benefit other members of your household. Only authorized personnel will share client information needed for service delivery, program eligibility, to track demographic trends, service patterns, and any outcomes achieved.

Non-personally identifying information may also be used for the purposes of research and reporting to other service agencies, current and potential program funding sources, and other programs offered by community action and its partners. I release the State of West Virginia and its grant subrecipients from any legal liability for disclosing or acquiring information that you have provided. Unless I make a formal request to the Community Action Agency that I no longer want to participate in the services offered, this release will remain in force. The information and statements made by me in this application is be true, correct, and complete to the best of your knowledge.

Customer Signature

Date

Signature of CAA Staff Member

Date



West Virginia Department of Human Services
Zero Income/Home Heating Cost Verification Form

I hereby verify that my income for the month and year of _____ is/will be zero.

My living expenses are:

☐

Food

☐

Home Heating

☐

Clothing

☐

Utilities

☐

Shelter

☐

Other _____

Please state below how you have provided for the costs of the items checked above:

Applicant's Signature

Date

You must obtain the signature, name, address and phone number of the person who can verify the information you provided above. This must be entered below before a decision can be made on your application. Return this form with the required information as instructed by the Worker.

I certify that the above information provided by _____ is true and correct to the best of my knowledge.

Name: _____

Address: _____

Phone: _____

Signature

Date