Sac and Fox Nation

920883 S. Highway 99, Building A, Stroud, OK 74079
Phone: (918) 968-3526• Fax: (918) 968-0142

LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM
EMERGENCY ASSISTANCE

CASE NAME: _____ CASE NUMBER: _____

I have previously received Low Income Energy Assistance from:

_____   _____   _____
AGENCY   CITY   COUNTY

For the period covering _____ to _____ for _____
　　　　　　　　　　　(MO/YR)　　　　　　　　(MO/YR)　　　　　(Electric, Gas, Propane, Wood)

In the amount of _____ Paid on _____.
　　　　　　　　　　　　　　　　　　　　　　(MO/DAY/YR)

However, since receipt of the above stated assistance, the rising cost of home energy has continued to be excessive in relation to my household income. Therefore, I am declaring an emergency exists and further assistance is necessary to meet the rising costs of home energy.

I certify that this application for assistance is not for any energy costs previously paid by the above agency and that in no way is this application requested for the purpose of duplication of payments.

I have been informed that any person who knowingly, willfully and fraudulently provides false information for the purpose of obtaining benefits which they are ineligible to receive may be subject to prosecution to the fullest extent to the appropriate state of federal statute.

_____
SIGNATURE

_____
DATE

Additional Information

_____

_____

_____

LIHEAP Crisis Eligibility

Eligibility for the Energy Assistance Program is based on average **GROSS** monthly income from the previous month. The following chart will help you determine if you should apply.

Household Size	Monthly Gross Income
1	$1718
2	$2247
3	$2776
4	$3304
5	$3833
6	$4362
7	$4461
8	$4560
9	$4659
10	$4758

Important Rights Notice

Any person whose application is denied or not acted upon within reasonable promptness, or whose benefits are reduced or terminated has a right to a hearing.

If you desire a hearing, you may submit a request in writing to the following:

> Business Committee
> Sac and Fox Nation
> 920883 S. Hwy. 99, Bldg. A
> Stroud, OK 74079

You must make your request within ten (10) days after you receive a notice of decision on your application.
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(FOR OFFICE USE ONLY)

Income verification reviewed: □ Yes   □ No   If yes, what type: _____

Total Monthly Income: _____   Decision: □ Approved   □ Denied

Reason for above decision: _____

Social Service Representative: _____   Date: _____