

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM EARNINGS STATEMENT

	Return this form to:	
Every over Marco		
EMPLOYER NAME:		
Section I		
We request that you complete this fo specified below. If you no longer emp	rm to help our agency accurately de ploy this individual, please provide t	termine eligibility and benefits for the employee he information that you have.
EMPLOYEE NAME:		LAST FOUR (4) OF SSN:
LAST DATE OF EMPLOYMENT:		
Section II		
	ES AND GROSS EARNINGS PAID TO THIS	
Month:		
Date Paid	Gross Amount (Before Any Deductions)	INDICATE THE DAYS THAT CHECKS ARE RECEIVED
		SU M T W TH F S
		_
		-
Section III		
		THAT WERE PAID FROM FUNDS NOT OWED TO THE
Date Paid	Type of Expense	DURING THE MONTH(S) INDICATED IN SECTION 2. Amount Paid
	**	
I attest and certify that th	he above information is factual and o	correct to the best of my knowledge.
Employer's Signature	Date	Telephone
Title of Person Completing Fo	rm	
Company's Address:	City	State, Zip

You may return this form to us using the contact information at the top of this form. You are also welcome to contact our local LIHEAP Administrative office with questions.