LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

EARNINGS STATEMENT

Return this form to:

EMPLOYER NAME: _____

Section I

We request that you complete this form to help our agency accurately determine eligibility and benefits for the employee specified below. If you no longer employ this individual, please provide the information that you have.

EMPLOYEE NAME: _____ **LAST FOUR (4) OF SSN:** _____

LAST DATE OF EMPLOYMENT: _____

Section II

PLEASE INDICATE THE PAYMENT DATES AND GROSS EARNINGS PAID TO THIS EMPLOYEE DURING

Month: _____ Year: _____

Date Paid	Gross Amount *(Before Any Deductions)*

INDICATE THE DAYS THAT CHECKS ARE RECEIVED

SU	M	T	W	TH	F	S
☐	☐	☐	☐	☐	☐	☐

Section III

PLEASE INDICATE ANY HOUSEHOLD EXPENSES YOU PAID FOR THIS EMPLOYEE THAT WERE PAID FROM FUNDS NOT OWED TO THE EMPLOYEE AS A PART OF YOUR EMPLOYMENT AGREEMENT, AND WERE PAID DURING THE MONTH(S) INDICATED IN SECTION 2.

Date Paid	Type of Expense	Amount Paid

I attest and certify that the above information is factual and correct to the best of my knowledge.

Employer's Signature _____ Date _____ Telephone _____

Title of Person Completing Form _____

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.