



## 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 DAY 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 IN ADDITION TO EARNINGS, 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 SignatureDateTelephone

\_\_\_\_\_

Title of Person Completing Form

\_\_\_\_\_

Company's Address:CityState, 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.**