Low Income Home Energy Assistance Program

Earnings Statement

Return this form to:

EOA of Washington County
614 E Emma Ave. Ste. M 401
Springdale, AR 72764
Email: Liheap@eoawc.org
Phone: 479-872-7479/ Fax: 479-872-7482

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 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.