LIHEAP CARES ACT Questionnaire

For LIHEAP & OEAP during COVID-19

Name: _____ Date: _____

Has anyone in your household been affected by COVID-19? ☐ Yes ☐ No

If **Yes** above, how?

☐ Loss of Employment Employer: _____

☐ Loss or Reduction in hours/income

☐ Other (please explain)

_____

_____

_____

_____

_____

_____

By signing this form, I agree that the above information is true.

_____ _____

Signature Date