

# APPLICATION FOR SERVICES

SERVICE APPLYING FOR: ☐ NUTRITION ☐ HEALTH ☐ EMERGENCY SERVICES ☐ OTHER  
☐ EMPLOYMENT ☐ EDUCATION ☐ INCOME MANAGEMENT ☐ HOUSING

For Agency Office Use Only

Date Application Received: \_\_\_\_\_

Date Application Completed: \_\_\_\_\_

Application Status: ☐ Approved ☐ Denied

Applicant Name (first & last):			Telephone:		
			Cell:		
Current Address:		City:	State:	Zip:	
County:		Email:			
Mailing Address (If different from Current Address):		City:	State:	Zip:	

LIST ALL HOUSEHOLD MEMBERS (INCLUDING APPLICANT- Begin with applicant, then spouse, then oldest child, etc.). USE ADDITIONAL PAPER IF YOU NEED MORE SPACE

NAME (must provide first and last name)	MARITAL STATUS	RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	SEX	RACE (Optional to Provide) White, Black, Hispanic, Asian/Pacific Islander, Native American, Native Alaskan, Other - define	VETERAN	HIGHEST GRADE OF SCHOOL COMPLETED	DOES HOUSEHOLD MEMBER RECEIVE REGULAR FINANCIAL ASSISTANCE FOR A PERMANENT DISABILITY?	HAVE YOU PREVIOUSLY RECEIVED ASSISTANCE FROM THIS AGENCY?	RECEIVE FOOD STAMPS, SUPPLEMENTAL SECURITY INCOME, FAMILIES FIRST CASH ASSISTANCE (INDICATE ANY RECEIVING)
Applicant Name:								Y or N		Y or N	Y or N	
Household Member:								Y or N		Y or N	Y or N	
Household Member:								Y or N		Y or N	Y or N	
Household Member:								Y or N		Y or N	Y or N	
Household Member:								Y or N		Y or N	Y or N	
Household Member:								Y or N		Y or N	Y or N	

HOUSING (please check one) ☐ OWN ☐ RENT ☐ SECTION 8 ☐ PUBLIC HOUSING AUTHORITY ☐ HOMELESS ☐ HUD

Are the Utilities included with the rent? Y or N If yes, which utilites are included? ( ) Electric ( ) Water ( ) Gas

HOUSEHOLD TOTAL INCOME (Below list income information for applicant and all household members). Use additional paper if more space is needed.

NAME	SOURCE OF INCOME <input type="checkbox"/> Employment <input type="checkbox"/> SS / SSI / VA <input type="checkbox"/> TANF <input type="checkbox"/> Child Support <input type="checkbox"/> Unemployment <input type="checkbox"/> Other	FT / PT	HIRE DATE	GROSS MONTHLY INCOME	IF EMPLOYED, PROVIDE EMPLOYER'S NAME & ADDRESS	Is the income reliable?
						Y or N
						Y or N
						Y or N
						Y or N
						Y or N
						Y or N

Does anyone in the household receive SNAP (food stamps) benefits? Y or N if yes, how much \$ \_\_\_\_\_

Does anyone in the household receive a Utility Assistance Check? Y or N If yes, how much \$ \_\_\_\_\_

**DOCUMENTATION OF INCOME REQUIRED:**

► NOTE: YOU MUST ATTACH INCOME DOCUMENTATION FOR EVERY PERSON IN HOUSEHOLD ◀

**ATTACH ALL INCOME DOCUMENTATION HERE**

**CSBG STATEMENT OF NEED**

Please tell us why you need assistance on the lines below: (please print)

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Please tell us how you plan to address your situation going forward, what are your goals?

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**Applicant Certification:**

I certify that all of the information provided by me is true and correct. I authorize the verification of any and all information provided herein to determine my eligibility, and acknowledge I have been informed of the appeal process. I understand that I will be notified in writing of my eligibility status. Identifying information provided by you for determination of your eligibility for CSBG and for the provision of services from the program will be considered confidential, unless otherwise authorized or required by law, will not be shared with any other persons or agencies except for the purposes directly related to the administration of the CSBG program. I attest under penalty of perjury that all persons applying for or receiving aid are either a United States citizen or qualified alien as defined by 8 U.S.C § 1641(b), or eligible immigrants. I swear under penalty of perjury (a crime for lying under oath) and all other applicable penalties that the statements made on this application, any attachments, and to whoever interviewed me are true and correct. I understand that anyone who fraudulently covers up a material fact or who knowingly gives false information for the receipt of CSBG assistance is liable upon conviction of a fine of \$10,000 or imprisonment for not more than five years, or both.

I DO \_\_\_\_ OR DO NOT \_\_\_\_ AGREE THAT THE INFORMATION CONTAINED IN MY APPLICATION MAY BE SHARED WITH OTHER AGENCIES FROM WHICH I SEEK ADDITIONAL SERVICES.

APPLICANT SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

If Representative for Applicant, give relationship and reason for signing: \_\_\_\_\_

**NO PERSON ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, SEX, AGE, DISABILITY, ANCESTRY, STATUS AS A VETERAN, OR ANY OTHER CHARACTERISTICS PROTECTED BY FEDERAL, STATE, OR LOCAL WILL BE EXCLUDED FROM PARTICIPATION IN, OR BE DENIED BENEFITS OF, OR BE OTHERWISE SUBJECTED TO DISCRIMINATION IN THE OPERATION OF THE CSBG PROGRAM.**

**To Be Completed By Agency Staff Only:**

Number in Household: \_\_\_\_\_  
Total Monthly Income: \_\_\_\_\_  
Total Annual Income \_\_\_\_\_

% of Poverty \_\_\_\_\_

**Eligibility:**

**Method of Eligibility:** Verification or Self-Declaration **National Goal: #1** \_\_\_\_\_ **#6** \_\_\_\_\_

**Customer Notification:** Verbal or Written **Goal Was:** Achieved Maintained Not Achieved

**Eligibility Period:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ **Explain:** \_\_\_\_\_

**INTAKE WORKER SIGNATURE:** \_\_\_\_\_ **DATE CERTIFIED:** \_\_\_\_\_

**SIGNATURE OF DETERMINING AGENCY OFFICIAL:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

DCEA Application 12/14