

# APPLICATION FOR CSBG SERVICES

◆ Community Services Block Grant ◆

SERVICE APPLYING FOR:  NUTRITION  HEALTH  EMERGENCY SERVICES  OTHER  
**APPLICATION FOR CSB**  EMPLOYMENT  EDUCATION  INCOME MANAGEMENT  HOUSING

◆ Community Services Block Grant ◆

|                             |   |
|-----------------------------|---|
| For Agency Office Use Only  |   |
| DATE APPLICATION RECEIVED:  | _____   |
| DATE APPLICATION COMPLETED: | _____   |
| APPLICATION STATUS:         | <input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED |

|  |        |            |      |
|--|--------|------------|------|
| Applicant Name (first & last):                       |        | Telephone: |      |
| Current Address:                                     |        | Cell:      |      |
| 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<br>(must provide first and last name) | MARITAL STATUS | RELATIONSHIP TO APPLICANT | SOCIAL SECURITY NUMBER | DATE OF BIRTH | AGE | SEX | RACE<br>(Optional to Provide)<br>White, Black, Hispanic, Asian/Pacific Islander, Native American, Other 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

**CHILD CARE: Do you have child care? Y or N Is it reliable? Y or N**  
 I don't have any children.     I pay for childcare: \$ \_\_\_\_\_ / week. Type of care: \_\_\_\_\_     I have subsidized childcare.  
 A friend or family member provides childcare.     My child / children participate in Head Start/Early Head Start. Which location? \_\_\_\_\_  
 My child/children are in school with appropriate after school care.     My child/children are in school without appropriate after school care.  
 I do not have affordable child care options.    Other: \_\_\_\_\_.

**HEALTH: Do you have health insurance? Y or N**  
 I have medical insurance provided by my employer.     My household members have medical insurance provided by my employer.     I am provided sick leave benefits.  
 I have a retirement plan that includes health insurance.     My household members have TennCare, Medicaid, Medicare, or some other medical insurance provided by the government.  
 I do not have medical insurance.     My household members do not have medical insurance.     I have supplemental prescription assistance to help pay for medications.  
 I have a copay for my medications.     I do not have supplemental medical insurance to help pay for medications.  
 I (or any household members) often go without my medication due to lack of money.     Other: \_\_\_\_\_  
 I / my child (ren) have a medical condition that affects my ability to contribute to my household. If so, please explain: \_\_\_\_\_

**NUTRITION: Does your family experience food insecurity for 1 or more times throughout the month? Y or N Is satisfied through food banks / commodities? Y or N**

**SUPPORTS: Do you have other family, community, or agency supports? Y or N If yes, please explain**

**TRANSPORTATION: Do you have transportation Y or N? Is it reliable? Y or N? Public or Private?**

**EMERGENCY NEEDS: I am currently in need of the following emergency assistance:**

**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   | FT / PT | HIRE DATE | GROSS MONTHLY INCOME | IF EMPLOYED, PROVIDE EMPLOYER'S NAME & ADDRESS | Is the income reliable? |
|------|--|---------|-----------|----------------------|--|-------------------------|
|      | <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 |         |           |                      |  |                         |
|      |  |         |           |                      |  | Y or N                  |
|      |  |         |           |                      |  | Y or N                  |
|      |  |         |           |                      |  | Y or N                  |
|      |  |         |           |                      |  | Y or N                  |
|      |  |         |           |                      |  | Y or N                  |
|      |  |         |           |                      |  | Y or N                  |

**SOURCE OF INCOME:**

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

**CSBG STATEMENT OF NEED**

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

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

**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: \_\_\_\_\_

**DATE/TIME TAKEN:** \_\_\_\_\_

**Eligibility:**

**Method of Eligibility:** Verification or Self-Declaration

**Customer Notification:** Verbal or Written

**National Goal: #1** \_\_\_\_\_ **#6** \_\_\_\_\_ **#6** \_\_\_\_\_

**Goal Was:** Achieved   Maintained   Not Achieved

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

**Explain:** \_\_\_\_\_

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

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