APPLICATION FOR CSBG SERVICES

♦ Community Services Block Grant ♦

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

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 ☐ Employment ☐SS / SSI / VA ☐TANF ☐ Child Support ☐ Unemployment ☐ 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

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***_____
Goal Was: *Achieved Maintained Not Achieved*

Eligibility Period:_____ /_____ /_____ ***to*** _____ /_____ /_____

Explain: _____

INTAKE WORKER SIGNATURE:_____ ***DATE CERTIFIED:*** _____

SIGNATURE OF DETERMINING AGENCY OFFICIAL:_____ ***DATE:***_____