

Please Print

File No: _____

County: _____

Service Worker: _____

FAMILY INFORMATION

Applicant Name: _____ Email: _____

Mailing Address: _____ Home Phone: _____

City: _____ Zip Code: _____ Other Phone: _____

Does your household receive food stamps? What is the monthly allotment? _____

Yes No

LIST ALL HOUSEHOLD MEMBERS, INCLUDING APPLICANT:

NAME	RELATION TO H.H.	SEX	S.S.N.	DOB	EDUC	RACE	MONTHLY INCOME	HLTH INSUR	DIS.
	SELF								
							\$	TOTAL	

LIVING QUARTERS: OWNED OR BEING BOUGHT RENT SUBSIDIZED PHA SUBSIDIZED OTHER (SEC. 8)

HOMELESS RENT-FREE LIVING WITH FAMILY MEMBERS OTHER

OTHER CHARACTERISTICS: SINGLE SINGLE PARENT TWO PARENT H.H 2 ADULTS NO CHILDREN

GRANDPARENT/GRANDCHILDREN WIDOWED DIVORCED SEPERATED

PRIMARY SOURCE OF FAMILY INCOME: 1=NO INCOME 2=AFDC 3=SSI 4= SOC. SEC.

5= PEN. OR VA. 6= GEN. ASST 7= HEALTH NEEDS 8= EMPLOYMENT 9=ANY OTHER SOURCE

10= CHILD SUPPORT

NEEDS OF FAMILY MEMBERS: EMERGENCY NEEDS HOUSING NEEDS ENERGY ASSISTANCE

NUTRITIONAL NEEDS TRANSPORTATION EMPLOYMENT NEEDS HEALTH NEEDS

EDUCATIONAL NEEDS LEGAL NEEDS CHILD CARE OTHER

EXPENSES: HOUSING- \$_____ H/W- H/B- MH- APT ELECTRICITY- \$_____ GAS- \$_____ WATER- \$_____

MEDICAL- \$_____ FOOD- \$_____ LAND PAYMENT- \$_____ DAYCARE- \$_____ LOT RENT- \$_____

Do you have any trees around your home? _____

CUSTOMER'S CERTIFICATION: I, the undersigned, certify to the best of my knowledge that the above information is true and I authorize the verification of any and all information for the purpose of determining income eligibility for the Community Services Block Grant Program. I understand that I am subject to all applicable Federal and State laws concerning fraud if I knowingly give false or incomplete information to obtain assistance. I understand that I have the right appeal if my application is denied.

Customer's Signature: _____ Representative Signature: _____ Date: _____