KNOXVILLE-KNOX COUNTY COMMUNITY ACTION COMMITTEE
Community Service Block Grant Application for Services

Please complete the following application. If you need assistance, please ask staff.

Head of Household

First Name	Middle Name or Initial	Last Name

Gender	Date of Birth	Social Security Number

Primary Address	City or Town	State	Zip	County

Primary Telephone	Secondary Telephone	Email Address (optional)

Mailing Address (if different from above)	City or Town	State	Zip	County

Race: ☐White ☐Asian ☐American Indian/Alaska Native ☐Other
☐Black/African American ☐Multi-Racial ☐Native Hawaiian/Other Pacific Islander

Veteran? ☐Yes ☐No
Active Military? ☐Yes ☐No
Hispanic/Latino? ☐Yes ☐No

Citizenship Status: ☐U.S. Born/Naturalized ☐Eligible Legal Resident ☐Non-Eligible Legal Resident ☐Undocumented Resident

Work Status, age 18 and older: ☐Full Time ☐Part Time ☐Retired ☐Migratory Worker ☐Unemployed less than 6 months ☐Unemployed over 6 months ☐Not in Labor Force

Education, age 14 and older: ☐0-8th Grade ☐High School Grad/GED ☐2 or 4 Yr. College Grad ☐9-12th (Non-Grad/No GED) ☐12+ Some College ☐Graduate of Other Post Grad. School

If age 14-24, are you in school? ☐ Yes ☐ No

Do you have a Disability? ☐ Yes ☐ No

Do you have a Chronic Illness? ☐ Yes ☐ No

Do you have Medical Insurance? ☐ Yes ☐ No

If yes, what are your health insurance sources? (Check all that apply)
☐Medicaid ☐Direct-Purchase ☐State Children's Health Insurance Program
☐Medicare ☐Military Health Care ☐State Health Insurance for Adults ☐Employment Based

Household Information ***How many total people are in your household?*** _____

Family Type: ☐Single Person ☐Two Parent Household ☐Two Adults NO Children ☐Non-Related Adults with Children ☐Single Parent Female ☐Multigenerational ☐Single Parent Male ☐Other

Home Type: ☐Own ☐Rent ☐Homeless ☐Other Permanent Housing ☐Other

Household Income ***What is your total household income? Include all family members.*** _____

Sources: ***(Check all that apply to your household)*** ☐Employment ☐Other Income Source ☐Non-Cash Benefits ☐No Income

Other Income Sources: *(Check all that apply to your household)* ☐TANF ☐Child Support ☐Unemployment ☐Worker's Comp ☐Social Security ☐EITC ☐Alimony ☐VA Disability ☐VA Pension ☐Work Pension ☐SSI ☐SSDI ☐Private Disability ☐Other

Non-Cash Benefits: ***(Check all that apply to your household)*** ☐SNAP ☐WIC ☐LIHEAP ☐Section 8 ☐Subsidized Housing ☐HUD-VASH ☐Permanent Supportive Housing ☐Affordable Care Act Subsidy ☐ Child Care Voucher ☐Other

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Head of Household Name: _____

Household Members *(Complete for everyone who lives with you. Please use additional sheets as needed.)*
Note: Assistance cannot be extended to any applicant who does not provide Social Security Numbers, and verification of, for everyone in applicant's household.

First Name	Middle Name or Initial	Last Name

Gender	Date of Birth	Social Security Number

Relationship to head of household: ☐Spouse ☐Child ☐Foster Child ☐Grandchild ☐Not Related ☐Parent ☐Grandparent ☐Adult Child ☐Other Relation ☐Other

Race: ☐White ☐Asian ☐American Indian/Alaska Native ☐Other ☐Black/African American ☐Multi-Racial ☐Native Hawaiian/Other Pacific Islander

Veteran? ☐Yes ☐No
Active Military? ☐Yes ☐No
Hispanic/Latino? ☐Yes ☐No

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If age 14-24, are they in school? ☐ Yes ☐ No

Do they have a Disability? ☐ Yes ☐ No

Do they have a Chronic Illness? ☐ Yes ☐ No

Do they have Medical Insurance? ☐ Yes ☐ No

If yes, what are their health insurance sources? (Check all that apply)
☐Medicaid ☐Direct-Purchase ☐State Children's Health Insurance Program ☐Medicare ☐Military Health Care ☐State Health Insurance for Adults ☐Employment Based

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Head of Household Name: _____

Income Information *(Complete for all household members over age 18; use additional sheets if needed)*

Proof of income documentation will be required on all household members over age 18: Work stubs; Pension or Social Security statements; DHS proof of income accepted.

Name	Gross Monthly Income	Is this income reliable?	What documentation have you provided?
		☐Yes ☐No	☐ Pay Stubs ☐ DHS proof of income ☐ Pension or Social Security statements ☐ Other
		☐Yes ☐No	☐ Pay Stubs ☐ DHS proof of income ☐ Pension or Social Security statements ☐ Other
		☐Yes ☐No	☐ Pay Stubs ☐ DHS proof of income ☐ Pension or Social Security statements ☐ Other
		☐Yes ☐No	☐ Pay Stubs ☐ DHS proof of income ☐ Pension or Social Security statements ☐ Other

Statement of Need:

Please tell us what you need assistance with today on the lines below: (please print)

_____

_____

Applicant Certification: I certify that all 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 understand that the information on this form may be used in statistical reports and I hereby give my permission to use the information collected about me if it does not identify me personally by name.

I DO ☐ I 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 CHARACTERISTIC 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/ESG PROGRAM.

For CSBG Funded Programs & CSBG Staff Only, to be Completed at File Opening:

Total Number in Household: _____

Total Monthly Income: $_____

Total Annual Income: $_____

Household Eligibility: Within guideline ☐ Exceeds guideline ☐

Method of Eligibility: Verification ☐ or Self-Declaration ☐

APPLICATION STATUS: **APPROVED** ☐ **DENIED** ☐

Client Notification: Verbal ☑ **Client Notified of Grievance Procedures:** ☑

Eligibility Period: _____/_____/_____

to _____/_____/_____

Household Percent of Poverty

0 -50 %	☑	101-125%	☑	176-200%	_____
51-75%	☑	126-150%	_____	201-250%	_____
76-100%	☑	151-175%	_____	251% & over	_____

National Goal: **#1** ☑ **#2** _____ **#3** _____

Goal was: ☐ **Achieved** ☐ **Maintained** ☐ **Not Achieved**

Explain: _____

_____

Intake Worker Signature

_____

Date Certified