

CAMPBELL COUNTY CARE BOARD

COMMUNITY SERVICES BLOCK GRANT (CSBG) APPLICATION FOR ASSISTANCE

Type of Assistance Requested: _____ Date: _____

Agency: _____

PERSONAL INFORMATION FOR APPLICANT					
Applicant Name:			Telephone:		
Physical Address:		City:	County:	State:	
Mailing Address:		City:	County:	State:	
Date of Birth:	Age:	Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unspecified		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unspecified	
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Unspecified		Race <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Island <input type="checkbox"/> Other <input type="checkbox"/> Unspecified <input type="checkbox"/> White		Education <input type="checkbox"/> 0-8 <input type="checkbox"/> 12 Grade + Post-Secondary <input type="checkbox"/> 2-4 Years College Graduate <input type="checkbox"/> 9-12 Non-Graduate <input type="checkbox"/> GED <input type="checkbox"/> Graduate of Post-Secondary <input type="checkbox"/> High School Graduate <input type="checkbox"/> Unspecified	
Employment: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed (more than 6 months) <input type="checkbox"/> Unemployed (less than 6 months) <input type="checkbox"/> Unemployed not in labor force <input type="checkbox"/> Unspecified			Health Insurance: <input type="checkbox"/> None <input type="checkbox"/> Direct-Purchase <input type="checkbox"/> Employment Based <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Military <input type="checkbox"/> State-Adult <input type="checkbox"/> State Children <input type="checkbox"/> Unspecified		
Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Unspecified <input type="checkbox"/> Widowed			Military Status: <input type="checkbox"/> Active <input type="checkbox"/> Unspecified <input type="checkbox"/> Veteran		
Disconnected Youth- Not Working or Not in School (for 14-24 age group): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unspecified					

INCOME INFORMATION FOR ALL HOUSEHOLD MEMBERS 18 AND OVER (Provide Documents)					
Name	Pay Per Hour	Hours Per Week	Pay Per Month	Total	Income Source

HOUSING INFORMATION	
Family Type:	<input type="checkbox"/> Multigenerational Household <input type="checkbox"/> Nonrelated adults with children <input type="checkbox"/> Unspecified <input type="checkbox"/> Other <input type="checkbox"/> Single Parent/Female <input type="checkbox"/> Single Parent/Male <input type="checkbox"/> Single Person <input type="checkbox"/> Two Adults/No Children <input type="checkbox"/> Two Parent Household
Household Size	<input type="checkbox"/> Single <input type="checkbox"/> Two <input type="checkbox"/> Three <input type="checkbox"/> Four <input type="checkbox"/> Five <input type="checkbox"/> Six or More
Housing:	<input type="checkbox"/> Homeless <input type="checkbox"/> Other <input type="checkbox"/> Unspecified <input type="checkbox"/> Other Permanent Housing <input type="checkbox"/> Own <input type="checkbox"/> Rent

ALL OTHER MEMBERS OF HOUSEHOLD (USE ADDITIONAL SHEET IF NECESSARY)						
#1	Name:	Gender:	DOB:	Race:	Education:	Disabled:
	Relationship to HOH:	Ethnicity:	Marital Status:	Military Status:	Disconnected 14-24 (No School /Work: :	Health Ins:
#2	Name:	Gender:	DOB:	Race:	Education:	Disabled:
	Relationship to HOH:	Ethnicity:	Marital Status:	Military Status:	Disconnected 14-24 (No School /Work: :	Health Ins:
#3	Name:	Gender:	DOB:	Race:	Education:	Disabled:
	Relationship to HOH:	Ethnicity:	Marital Status:	Military Status:	Disconnected 14-24 (No School /Work: :	Health Ins:
#4	Name:	Gender:	DOB:	Race:	Education:	Disabled:
	Relationship to HOH:	Ethnicity:	Marital Status:	Military Status:	Disconnected 14-24 (No School /Work: :	Health Ins:
#5	Name:	Gender:	DOB:	Race:	Education:	Disabled:
	Relationship to HOH:	Ethnicity:	Marital Status:	Military Status:	Disconnected 14-24 (No School /Work: :	Health Ins:

I certify that the documentation provided and the facts contained in this application are accurate and true to the best of my knowledge and understand that falsified statements on this application or in the documentation provided could result in being denied CSBG-funded assistance in Wyoming

SIGNATURE: _____ DATE: _____

SELF-DECLARATION FOR ZERO INCOME (Only Complete If No Source of Income)

Self-Declaration for zero income

Only complete if you have no source of income.

Please Check ALL that apply:

The Household has **no source** of Income

(I, _____, do hereby declare under penalty of perjury that I have received no income from any source during the past 30 days and that I have been unemployed during that time. **I have been able to maintain my basic necessities** by: _____

Applicant (Printed Name)

Signature

Date

Witness (Printed Name)

Signature

Date

Program Staff Use Only

<input type="checkbox"/> Copies of All Income for the Household during the last 30-90 days	% of Poverty Level _____ %	Income Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this allowable expense? <input type="checkbox"/> Yes <input type="checkbox"/> No
Applicant Status: <input type="checkbox"/> Approved <input type="checkbox"/> Denied	Explanation of denial of services:	Unduplicated # of People Served _____	# of Services Provided _____

Case Management Notes:

Referral(s) made:

Printed Staff Name:

Staff Signature:

Date Interview Conducted:

Documentation of service(s) provided, payment invoices, and cancelled check(s) or receipt of payment will be maintained in the file with this CSBG Application, the Eligibility Requirements Form, and copies of Income. In the event, the service is denied; a copy of the Denial Letter will be maintained in the file.

Council of Community Services



"helping people help themselves"

CSBG BLOCK GRANT MEDICAL/DENTAL SURVEY

Date _____

Name _____

___ Medical Appointment ___ RX ___ Dental Appointment

Condition Requiring Service:

What does this condition prevent you from doing?

Signature _____

For Office Use:

Date Voucher Issued: _____

Date of Payment: _____

30 day follow up:

Date _____

How has this service improved client's health and well-being? _____

Staff Signature _____

CSBG Customer Satisfaction Survey

AGENCY Name: Council of Community Services

Date(s) of Service: _____

Services Received: _____

Please fill out the survey below if you received CSBG services from the above-named agency. Your responses are completely anonymous. Please return to the agency you received funding from or please email your responses to BLR01@ccgov.net or call 307-687-6324.

COMMUNITY SERVICES BLOCK GRANT

Thank you for being our client. Please help us improve our service by completing this survey.

RATINGS	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
1) The staff volunteer treated me with courtesy and respect.	1	2	3	4	5
2) The staff/volunteer was responsive to my needs.	1	2	3	4	5
3) The staff/volunteer helped me to make progress towards achieving my goal(s).	1	2	3	4	5
4) As a result of the service(s) received, I feel my situation is more stable.	1	2	3	4	5
5) My questions and concerns were addressed in a timely manner.	1	2	3	4	5
6) My overall rating with the services received is satisfactory.		NO		YES	