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: ☐ Yes ☐ No ☐ Unspecified	Gender: ☐ Male ☐ Female ☐ Other ☐ Unspecified	
Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unspecified	Race ☐ American Indian/Alaska Native ☐ Asian ☐ Multi-Racial ☐ Black or African American ☐ Native Hawaiian or Other Island ☐ Other ☐ Unspecified ☐ White	Education ☐ 0-8 ☐ 12 Grade + Post-Secondary ☐ 2-4 Years College Graduate ☐ 9-12 Non-Graduate ☐ GED ☐ Graduate of Post-Secondary ☐ High School Graduate ☐ Unspecified	
Employment: ☐ Full-time ☐ Part-time ☐ Migrant Seasonal Farm Worker ☐ Retired ☐ Unemployed (more than 6 months) ☐ Unemployed (less than 6 months) ☐ Unemployed not in labor force ☐ Unspecified		Health Insurance: ☐ None ☐ Direct-Purchase ☐ Employment Based ☐ Medicaid ☐ Medicare ☐ Military ☐ State-Adult ☐ State Children ☐ Unspecified	
Marital Status: ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Single ☐ Unspecified ☐ Widowed		Military Status: ☐ Active ☐ Unspecified ☐ Veteran	
Disconnected Youth- Not Working or Not in School (for 14-24 age group): ☐ Yes ☐ No ☐ 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:	☐ Multigenerational Household ☐ Nonrelated adults with children ☐ Unspecified ☐ Other ☐ Single Parent/Female ☐ Single Parent/Male ☐ Single Person ☐ Two Adults/No Children ☐ Two Parent Household	
Household Size	☐ Single ☐ Two ☐ Three ☐ Four ☐ Five ☐ Six or More	Housing: ☐ Homeless ☐ Other ☐ Unspecified ☐ Other Permanent Housing ☐ Own ☐ 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

☐Copies of All Income for the Household during the last 30-90 days	% of Poverty Level ____%	Income Eligible? ☐Yes ☐No	Is this allowable expense? ☐Yes ☐No
Applicant Status: ☐ Approved ☐ 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.

WYCSP | Wyoming Community Services Program

Wyoming Department of Health
Public Health Division
Community Services Program

COVID-19 Affidavit of Eligibility
Attachment A

Name		Date of Assistance	

Individual		Family	
Gender:		Household Type:	
Age:		Household Size:	
Education Level:		# of Household Members 18+:	
Disconnected Youth:		Housing:	
Health:		Level of Household Income:	
Ethnicity/Race:		Sources of Household Income:	
Military Status:		Other Income Source:	
Work Status:		Non-Cash Benefits:	

By signing this statement, I am certifying that I am applying for assistance from a Community Services Block Grant (CSBG) funded agency and have no documented proof of income and I am eligible to receive services, as my household is at or below 125% of the Federal Poverty Level, due to the impacts of COVID-19. I further 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.

Applicant Signature _____ Date _____

Staff Signature _____ Date _____

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_____

114 South 4-J Road Gillette, WY 82716 | 307-686-2730 | www.ccsgillette.org

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	