Metropolitan Action Commission
Application for CSBG Services (Community Service Block Grant)

Service applying for: [] Nutrition [] Health []Emergency Services [] Other []MAC4Jobs
[] Education [] Income Management [] Housing

For Agency Office Use Only
Date Application Received: _____
Date Application Completed:_____
Application Status: Approved Denied

Applicant Name (First & Last)			Home Phone:
Current Address:	City		Cell Phone:
County:	State	Zip	Email Address
Mailing Address (If different from current address)	State	Zip	

LIST ALL HOUSEHOLD MEMBERS INCLUDING APPLICANT. USE ADDITIONAL PAPER IF YOU NEED MORE SPACE

NAME (Must provide first and last name	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	Highest Grade of School Completed	Veteran (Yes or No)	Do you Receive Food Stamps (yes or no)	Have you previously received assistance from this agency (yes or no)
Applicant										
Household Member										
Household Member										
Household Member										
Household Member										
Household Member										

Housing (please check one) []Own []Rent []Section 8 []Public Housing Authority [] Homeless [] HUD

Child Care: Do you need child care? Y or N If yes, it is reliable? Y or N
[]I don't have any children [] I pay for child care $_____/week. Type of care: _____ [] I have subsidized childcare (certificate)
[] A friend or family member provides care [] 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 [] 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 supplemental 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 my medications. [] I (or any household members) often go without my medication due to lack of money. [] Other: _____
[]I 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 Are you 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. Do you have a ___car ___bus ___ ride with family or friends __ Other _____ Is it reliable? Y or N

Income (List ALL income information for applicant all ALL other household members. Use additional paper if more space is needed
(You must attach income documents for every person with income in the household)

Name	Source of Income	Gross Monthly Income	If employed, provide employer's name and address	Hire date (if applicable)	Full-time, Part-Time, Temporary Seasonal	Is the income reliable?
	[]Employment [] SS/SSI/VA []TANF [] Child Support []Unemployment [] Other _____					
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CSBG Statement of Need (please tell us why you need assistance)-Please print

How many people living in the home		How close is the nearest…	Please Check Services
____Under 1 year ___ 4 years old	__12-23 months ___5 years old	Head Start or child care Center ___ 5 miles or less	__ Education ___Employment __Nutrition ___Health __ Emergency Services
__65 years or older	___How many disabled? Ages _____	___More than 5 but less than 10 ___15 or more ___I don't know	___ Legal Services ___ESL __Budget/Financial Management

Employment	Adult Education	Housing
__Unemployment __Temp/PT/Seasonal __Permanent Stable job without benefits __Permanent Stable job with benefits	__No GED or HS diploma; cannot read or write __No HS diploma or GED; has basic skills __HS diploma/GED; functional math and literacy skill __Enrolled in post-secondary or other training class __Has certificate, AAS, BS, Masters, or higher	__Homeless, substandard, __Unaffordable, transitional, temporary shelter, safe __Safe/secure, subsidized public housing __Safe/secure, nonsubsidized; renter __Safe/secure, nonsubsidized; homeowner

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 our receiving aid are either a United States citizen or qualified person as defined by 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 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

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 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

Number in Household _____
Total Income: _____
Total Annual Income: _____
Eligibility:
Method of Eligibility: Verification or Self-Declaration
Customer notification: Verbal or written
Eligibility Period: ___/___/___ to ___/___/___
Intake worker signature: _____
Determining agency official signature _____

Date/Time taken : _____

National Goal: #1 or #6
Goal was: Achieved Maintained Not achieved
Explain: _____

Date certified: _____
Date: _____

3/31/2020