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	Race	Education
☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unspecified	☐ American Indian/Alaska Native ☐ Asian ☐ Multi-Racial ☐ Black or African American ☐ Native Hawaiian or Other Island ☐ Other ☐ Unspecified ☐ White	☐ 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	Health Insurance
☐ 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	☐ None ☐ Direct-Purchase ☐ Employment Based ☐ Medicaid ☐ Medicare ☐ Military ☐ State-Adult ☐ State Children ☐ Unspecified

Marital Status	Military Status
☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Single ☐ Unspecified ☐ Widowed	☐ 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.

THE EMERGENCY ASSITANCE PROGRAM (TEFAP)

CERTIFICATION OF ELIGIBILTY AND DISTRIBUTION RECIEPT

NAME _____ NUMBER IN HOUSEHOLD _____

ADDRESS _____ NUMBER OF ADULTS _____

_____ NUMBER OF CHILDREN _____

TELEPHONE _____

This table shows a monthly gross income for each family size. If your household income is at Or below the income listed for the number of people in your household, you are eligible to receive food.

October 1, 2020 through September 30, 2021

Persons in Household	Monthly Income	Annual Income
1	$2,127.00	$25,520.00
2	$2,873.00	$34,480.00
3	$3,620.00	$43,440.00
4	$4,367.00	$52,400.00
5	$5,113.00	$61,360.00
6	5,860.00	$70,320.00
7	$6,607.00	$79,280.00
8	$7,353.00	$88,240.00

You are also eligible to receive food from TEFAP if your household participates in any of the Following programs. UF you participate in one of these programs please check the box next to it.

	Food Stamps
	Power

Please read the following state carefully then sign the form and write in the date.

I certify the my monthly gross income is at or below the listed income on this form for the number of people in my household or that my household participates in the program checked on this form. I also certify that, as of today, my household lives in the area served by the Wyoming Emergency Food Assistance Program. I also understand that commodities are for my personal use, and are not to be sold, traded or given away. This certification form is being completed in connection with the receipt of Federal assistance. Program officials may verify what I have certified to be true. I understand that making false statements my result in having to pay the State for the value of the food improperly issues to me and may subject me to criminal prosecution under State and Federal law.

_____ _____

Signature Date

TEFAP is available to all eligible people regardless of race, color, national origin, sex, age, or handicap within the guidelines of USDA commodities available.

NAME:_____

Employment

- ☐ Unemployed for over 1 year
- ☐ Unemployed due to recent job loss
- ☐ Work part-time without benefits
- ☐ Work part-time WITH benefits
- ☐ Working full-time
- ☐ Working full-time above minimum wage ($7.25/hr)
- ☐ Not in the job market (receiving unemployment, disabled, etc.)

Housing

- ☐ Homeless
- ☐ Living in a car
- ☐ Living in a motel
- ☐ Staying in a shelter/transitional living
- ☐ Staying with friends temporarily
- ☐ Renting a mobile home, house, or apartment
- ☐ Own a home/paying mortgage

Education

- ☐ Not interested in furthering education/vocational training
- ☐ Interested in furthering education but not needed for job
- ☐ Interested in furthering education to get a better job, but lack resources
- ☐ Interested in furthering education to get a better job

How often do you have access to transportation?

- ☐ Rarely
- ☐ Sometimes
- ☐ Usually
- ☐ Always

Child Care

- ☐ No access/cannot afford childcare
- ☐ Child currently on waitlist for childcare
- ☐ Childcare reliably provided by paid friends/family
- ☐ Parent does not work, so they can care for child(ren)
- ☐ Childcare temporarily provided by friends/family
- ☐ Childcare reliably provided by unpaid friends/family
- ☐ Childcare provided by licensed provider
- ☐ N/A

How often did you reduce or skip meals because there was not enough food or money? (Nutrition)

- ☐ Most Days
- ☐ 7-10 Days
- ☐ 1-2 Days
- ☐ Never

Food Pantry

- ☐ This food pantry has food that is useful and that I enjoy
- ☐ I am unable to use some of the food I receive because I do not know how to prepare it
- ☐ I am unable to use some of the food I receive because it is food I do not like
- ☐ This food pantry does not meet the needs of my household's dietary restrictions
- ☐ I visit more than 1 food pantry each month

Healthcare

- ☐ You or a household member are putting off medical/dental visits because you can't afford them
- ☐ You or a household member have gone to the Emergency Room in the last 6 months
- ☐ You or a household member do not have a regular medical or dental healthcare provider
- ☐ You or a household member have not seen a doctor or dentist in over 2 years

Abuse

- ☐ You or a family member have been exposed to abuse

  Gillette Abuse Refuge Foundation (GARF) is a free and confidential resource for those experiencing abuse past or present. If you choose to reach out to GARF no legal or further action will be taken without your consent.
  GARF: 307-686-8071

- ☐ No one in your family has been exposed to abuse

Are you registered to vote?

- ☐ Yes
- ☐ No

Do you need help getting a driver's license or social security card?

- ☐ Yes
- ☐ No

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 _____

Pantry Client Information

- **Statistical information helps Food Bank of Wyoming receive food and funds to better serve Wyoming**
- **Information on this form is optional and confidential**
  - *However, eligibility for additional USDA products (TEFAP) do require replies as indicated by a star: ★*
- **All data will be digitally recorded using the safe and secure database - Link2Feed**
  - *Refer to "Our Data Promise" for details on information security*

If you have any questions regarding this form, please contact your local food pantry:

Site Name:_____ **Phone Number:**_____

Or Food Bank of Wyoming: 307-265-2172 or smaxwell@wyomingfoodbank.org

★Last name: _____ **★First name:** _____

Birthdate: ____/____/____ (mm/dd/yyyy) | **Gender:** _____ | **Marital Status:** _____

★Address: _____

Mailing; If Different: _____

★City: _____ **★State:** _____ **★Zip code:** _____

★County: _____ □ No fixed address/ Undisclosed

Housing Type (i.e. Own Home, Rental, Shelter): _____

ID Type Shown (if applicable): _____

Phone Number: _____ **Preferred Language(s):** _____

Referred By (i.e. friend, online, social worker): _____

Ethnicity/ Race: _____ **Highest Level of Education:** _____

Other Considerations:

- ☐ Homebound
- ☐ Veteran
- ☐ None
- ☐ Disability
- ☐ Other
- ☐ Undisclosed

★Total Number of Individuals in Household by age:

Children (0-18): _____ Adults (19-59): _____ Seniors (60+): _____

Additional Information

Last Name	First Name	Birthdate	Gender	Relation	Ethnicity/Race

★ Household Gross Monthly Income - Complete for each Household member

Household Member	Income Source	★Income Amount

Are you or those in your household enrolled in additional social assistance programs?

□ Yes □ No If yes, please explain: _____

Please list any dietary allergies or considerations:

_____

Other Comments:

_____

Council of Community Services

"helping people help themselves"

CSBG BLOCK GRANT PANTRY SURVEY

Date_____

Name_____

Number of Adults_____ Number of Children_____

How long have you been using our food pantry on a regular basis?

__3 months __ 6months __ 9 months __ 1 year __ More than 1 year

Do you reduce or skip meals because there is not enough food or money to purchase food? __ Yes __ No

If yes how often do you reduce or skip meals? _____

Reason for requesting continuing food assistance from our pantry:_____

_____

How does this food pantry help you increase your nutrition and cooking skills:_____

_____

Signature_____

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	