

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.

THE EMERGENCY ASSISTANCE PROGRAM (TEFAP)
 CERTIFICATION OF ELIGIBILITY AND DISTRIBUTION RECEIPT

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. If 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 Childcare temporarily provided by friends/family
 Child currently on waitlist for childcare Childcare reliably provided by unpaid friends/family
 Childcare reliably provided by paid friends/family Childcare provided by licensed provider
 Parent does not work, so they can care for child(ren) 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

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

<u>Household Member</u>	<u>Income Source</u>	<u>★ Income Amount</u>

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 6 months 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	