



Welcome to DYCD! This form lets you or your child apply to a DYCD program. You can only submit one application per person per location. Submitting a form does not guarantee eligibility or enrollment in the program and we might ask for more information to see if you are eligible. If accepted, the program will not cost you anything. We collect some information like *Gender, Race, Ethnicity, Language, and Health Insurance* status for planning purposes only. Your answers to these questions will not affect your status to benefits or services and will not be shared outside of DYCD without your permission. *Income, Household Information, and Education/Work* status might affect eligibility for certain programs. Gathering your information helps DYCD see who benefits from our programs. This helps us make our programs better and allows DYCD to continue giving communities the support they need.

Part I: Applicant Information

For the purposes of this application, *applicant* refers to the person applying to receive services. **Please select one:**

- ☐ I am completing this application for **myself** ☐ I am a parent or guardian completing this application **for my child**
☐ I am a relative/non-relative, completing this application **on behalf of the applicant**

Applicant's First Name:		Applicant's Last Name:		MI:	Applicant's Date of Birth (MM/DD/YEAR):
Applicant's Primary Address (Number and Street):				Applicant's Apt. Number:	
Applicant's City:			Zip Code:		
Applicant's Country of Origin: _____		Applicant's Gender Identity (Select all that Apply): <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-Binary (not Female or Male) <input type="checkbox"/> Gender Nonconforming <input type="checkbox"/> Two Spirit (Native American/First Nations) <input type="checkbox"/> Another Gender: _____ <input type="checkbox"/> Not Sure <input type="checkbox"/> Do not understand the question <input type="checkbox"/> Decline to Answer		Applicant's Sexual Orientation: <input type="checkbox"/> Heterosexual (straight) <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Pansexual <input type="checkbox"/> Asexual <input type="checkbox"/> Queer <input type="checkbox"/> Questioning <input type="checkbox"/> Not Sure <input type="checkbox"/> Another Sexual Orientation: _____ <input type="checkbox"/> Decline to Answer	
Applicant's Sex at Birth (Select One): <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> X (not male or female) <input type="checkbox"/> Not Sure					
Applicant's Gender Pronoun: <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> He/Him/His <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> Another Pronoun: _____ <input type="checkbox"/> Decline to Answer		Applicant's Race/Ethnicity (Select all that Apply): <input type="checkbox"/> American Indian and Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latinx/e/a/o <input type="checkbox"/> Middle Eastern/North African <input type="checkbox"/> Native Hawaiian and Other Pacific Islander <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Other: _____		Does the applicant identify as transgender? (Select One): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> Do not understand the question <input type="checkbox"/> Decline to Answer	



If of Asian origin, please select from the following (Select All That Apply): <div><input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Filipino <input type="checkbox"/> North Korean <input type="checkbox"/> South Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Laotian <input type="checkbox"/> Cambodian <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Hmong</div> <div><input type="checkbox"/> Indonesian <input type="checkbox"/> Malaysian <input type="checkbox"/> Pakistani <input type="checkbox"/> Sri Lankan <input type="checkbox"/> Taiwanese <input type="checkbox"/> Nepalese <input type="checkbox"/> Burmese <input type="checkbox"/> Tibetan <input type="checkbox"/> Thai <input type="checkbox"/> Other: _____</div>		If of Native Hawaiian or Other Pacific Islander origin, please select from the following (Select All That Apply): <div><input type="checkbox"/> Hawaiian <input type="checkbox"/> Guamanian <input type="checkbox"/> Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Fijian <input type="checkbox"/> Tongan <input type="checkbox"/> Other: _____</div>		If of Hispanic or Latinx/e/a/o origin, please select from the following (Select All That Apply): <div><input type="checkbox"/> Mexican, Mexican American, Chicana/o <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Dominican <input type="checkbox"/> Central American (including Salvadoran, Guatemalan, Honduran, etc.) <input type="checkbox"/> South American (including Ecuadorian, Colombian, Venezuelan, Panamanian etc.) <input type="checkbox"/> Another Hispanic, Latinx/e/a/o, Spanish Origin: _____</div>	
How well does the applicant speak English? (Select One): <div><input type="checkbox"/> Fluent/Very well <input type="checkbox"/> Well <input type="checkbox"/> Not well <input type="checkbox"/> Not well at all</div>		Applicant's Primary Language (Select One): <div><div><input type="checkbox"/> English <input type="checkbox"/> Bengali <input type="checkbox"/> Fulani <input type="checkbox"/> Haitian Creole <input type="checkbox"/> Hungarian <input type="checkbox"/> Korean <input type="checkbox"/> Punjabi <input type="checkbox"/> Portuguese <input type="checkbox"/> Spanish <input type="checkbox"/> Urdu <input type="checkbox"/> Other: _____</div><div><input type="checkbox"/> Albanian <input type="checkbox"/> Chinese* <input type="checkbox"/> German <input type="checkbox"/> Hebrew <input type="checkbox"/> Italian <input type="checkbox"/> Kru, Ibo, or Yoruba <input type="checkbox"/> Persian <input type="checkbox"/> Romanian <input type="checkbox"/> Tagalog <input type="checkbox"/> Vietnamese</div><div><input type="checkbox"/> Arabic <input type="checkbox"/> French <input type="checkbox"/> Gujarati <input type="checkbox"/> Hindi <input type="checkbox"/> Japanese <input type="checkbox"/> Mande <input type="checkbox"/> Polish <input type="checkbox"/> Russian <input type="checkbox"/> Turkish <input type="checkbox"/> Yiddish</div></div> <p>_____</p> <p><i>*including Cantonese and Mandarin</i></p>		Other Languages Spoken by Applicant (Select all that Apply): <div><div><input type="checkbox"/> English <input type="checkbox"/> Bengali <input type="checkbox"/> Fulani <input type="checkbox"/> Haitian Creole <input type="checkbox"/> Hungarian <input type="checkbox"/> Korean <input type="checkbox"/> Punjabi <input type="checkbox"/> Portuguese <input type="checkbox"/> Spanish <input type="checkbox"/> Urdu <input type="checkbox"/> Other: _____</div><div><input type="checkbox"/> Albanian <input type="checkbox"/> Chinese* <input type="checkbox"/> German <input type="checkbox"/> Hebrew <input type="checkbox"/> Italian <input type="checkbox"/> Kru, Ibo, or Yoruba <input type="checkbox"/> Persian <input type="checkbox"/> Romanian <input type="checkbox"/> Tagalog <input type="checkbox"/> Vietnamese</div><div><input type="checkbox"/> Arabic <input type="checkbox"/> French <input type="checkbox"/> Gujarati <input type="checkbox"/> Hindi <input type="checkbox"/> Japanese <input type="checkbox"/> Mande <input type="checkbox"/> Polish <input type="checkbox"/> Russian <input type="checkbox"/> Turkish <input type="checkbox"/> Yiddish</div></div> <p>_____</p> <p><input type="checkbox"/> Not applicable (only one language spoken by applicant)</p> <p><i>*including Cantonese and Mandarin</i></p>	
Is the applicant any of the following: <div><div>An Individual with a Disability? Parent/Legal Guardian? Offender/Justice Involved? Foster Care Participant? Runaway Youth? Veteran? Active Military Personnel? Victim of Domestic Violence? Victim of Human Trafficking?</div><div><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</div></div>		If the applicant is an individual with a disability, please select disability type(s) (Select all that Apply): <div><input type="checkbox"/> Cognitive impairment <input type="checkbox"/> Hearing-related <input type="checkbox"/> Learning disability <input type="checkbox"/> Mental or Psychiatric <input type="checkbox"/> Physical/Chronic Health Condition <input type="checkbox"/> Physical/Mobility Impairment <input type="checkbox"/> Vision-related <input type="checkbox"/> Other: _____ <input type="checkbox"/> Decline to Answer</div>		Did you or any member of your household serve in the armed forces, national guard, or reserves of the United States? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div> If yes, would you or your household member want to be contacted by the NYC Department of Veteran's Services? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>	



How did you learn about the DYCD program(s) you're applying to?
(Select all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Advertisement | <input type="checkbox"/> Referred by a Government agency |
| <input type="checkbox"/> Called 311 | <input type="checkbox"/> Referred by another organization where I was receiving services (i.e., case management, senior center, shelter, etc.) |
| <input type="checkbox"/> discoverDYCD | <input type="checkbox"/> School |
| <input type="checkbox"/> DYCD Community Connect | <input type="checkbox"/> Street fair, special event or street outreach |
| <input type="checkbox"/> DYCD Social Media | <input type="checkbox"/> Website (please specify which) _____ |
| <input type="checkbox"/> Family member, friend or neighbor | <input type="checkbox"/> Word of mouth |
| <input type="checkbox"/> House of worship | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Media (newspaper, radio, TV, etc.) | |

Part II: Applicant's Contact Information

☐ Contact information below is for the applicant

Phone Number #1

- ☐ Home
☐ Cell
☐ Work

Phone Number #2

- ☐ Home
☐ Cell
☐ Work

Email Address (Required):

Preferred Method of Contact:

☐ Cell Phone ☐ Home Phone ☐ Email ☐ U.S. Mail

Part III: Emergency Contact Information

Emergency Contact Name:

Emergency Contact Primary Phone Number:

- ☐ Home
☐ Cell
☐ Work

Emergency Contact Email Address:

Emergency Contact's Relationship to Applicant:

☐ Emergency contact is parent/guardian of applicant

Part IV: Applicant's Education/Work Status

Applicant's School Type (Select One):

- ☐ Full-Time Student**
☐ Part-Time Student**
☐ Not in School***

Applicant's current work status (Select One):

- ☐ Employed Full-Time
☐ Employed Part-Time
☐ Retired
☐ Unemployed (Short- term, 6 months or less)
☐ Unemployed (Long- term, more than 6 months)
☐ Unemployed (Not in labor force)
☐ Migrant Seasonal Farm Worker
☐ Not Applicable (Applicant is under 14 years of age)

If applicant is a *Part-Time Student* or *Full-Time Student*: **Please select applicant's current grade (Select One):

***If applicant is *Not in School*: **Please select the last grade completed by the applicant** (Select One):

Elementary School	<input type="checkbox"/> Pre-K	<input type="checkbox"/> K	<input type="checkbox"/> 1 st	<input type="checkbox"/> 2 nd	<input type="checkbox"/> 3 rd	<input type="checkbox"/> 4 th	<input type="checkbox"/> 5 th
Middle School	<input type="checkbox"/> 6 th		<input type="checkbox"/> 7 th			<input type="checkbox"/> 8 th	
High School	<input type="checkbox"/> 9 th	<input type="checkbox"/> 10 th	<input type="checkbox"/> 11 th	<input type="checkbox"/> 12 th	<input type="checkbox"/> Obtained High School Diploma	<input type="checkbox"/> Obtained High School Equivalency	
Community College	<input type="checkbox"/> 1 st Year		<input type="checkbox"/> 2 nd Year		<input type="checkbox"/> 3 rd Year	<input type="checkbox"/> 4 th Year	<input type="checkbox"/> Obtained Associate's Degree
Vocational/Trade School	<input type="checkbox"/> Some Vocational or Trade school credits, but no certificate or degree attained				<input type="checkbox"/> Obtained a certificate or degree from a Vocational or Trade school		
4-Year College/University	<input type="checkbox"/> Freshman		<input type="checkbox"/> Sophomore		<input type="checkbox"/> Junior <input type="checkbox"/> Senior		
Master's Degree:	<input type="checkbox"/> Some masters' degree credit, but no degree attained				<input type="checkbox"/> Obtained Master's Degree		
Professional Degree	<input type="checkbox"/> Some Professional Degree credits (e.g. MD, DDS, DVM, LLB, JD) but no degree attained				<input type="checkbox"/> Obtained Professional Degree (e.g. MD, DDS, DVM, LLB, JD)		
Doctorate Degree:	<input type="checkbox"/> Some Doctorate degree credits, but no degree attained				<input type="checkbox"/> Obtained Doctorate Degree		
Other	<input type="checkbox"/> Obtained Foreign Degree				<input type="checkbox"/> No Formal Schooling Attained		



Part V: Household Information

For all the next set of questions, **HOUSEHOLD** is defined as: any individual or group of individuals (family or non-family members) who are living together as one economic unit. **INCOME** is defined as the total annual gross income of all family and non-family members 18+years old living within the household.

The applicant lives in a household that is headed by (Select One):

- | | |
|---|--|
| <input type="checkbox"/> Single Parent - Female | <input type="checkbox"/> Two Adults – No Children |
| <input type="checkbox"/> Single Parent - Male | <input type="checkbox"/> Two Parent Household |
| <input type="checkbox"/> Single Person- No children | <input type="checkbox"/> Multigenerational Household |
| <input type="checkbox"/> Non-related adults with children | <input type="checkbox"/> Other |

Applicant's Housing Type (Select One):

- | | | |
|-----------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Own | <input type="checkbox"/> NYCHA | <input type="checkbox"/> Unhoused |
| <input type="checkbox"/> Rent | <input type="checkbox"/> Shelter | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Homeless | <input type="checkbox"/> Other Permanent Housing | |

Applicant's Household Size (Select One):

- | | | | |
|------------------------------------|-----------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> One | <input type="checkbox"/> Two | <input type="checkbox"/> Three | <input type="checkbox"/> Four |
| <input type="checkbox"/> Five | <input type="checkbox"/> Six | <input type="checkbox"/> Seven | <input type="checkbox"/> Eight |
| <input type="checkbox"/> Nine | <input type="checkbox"/> Ten | <input type="checkbox"/> Eleven | <input type="checkbox"/> Twelve |
| <input type="checkbox"/> Thirteen | <input type="checkbox"/> Fourteen | <input type="checkbox"/> Fifteen | <input type="checkbox"/> Sixteen |
| <input type="checkbox"/> Seventeen | <input type="checkbox"/> Eighteen | <input type="checkbox"/> Nineteen | <input type="checkbox"/> Twenty+ |

Applicant's Household 12-Month Gross Income:

\$ _____

Sources of Applicant's Household Income: (Select all that Apply):

- | | | | | | | |
|---|--|---|---|---|---|---|
| <input type="checkbox"/> Employment Wages | <input type="checkbox"/> Affordable Care Act Subsidy | <input type="checkbox"/> Alimony or Other Spousal Support | <input type="checkbox"/> Child Support | <input type="checkbox"/> Childcare Voucher | <input type="checkbox"/> Earned Income Tax Credit (EITC) | <input type="checkbox"/> Employment Tax Credit |
| <input type="checkbox"/> General Assistance | <input type="checkbox"/> Housing Choice Voucher | <input type="checkbox"/> HUD-VASH | <input type="checkbox"/> LIHEAP | <input type="checkbox"/> Pension | <input type="checkbox"/> Permanent Supportive Housing | <input type="checkbox"/> Private Disability Insurance |
| <input type="checkbox"/> Public Housing | <input type="checkbox"/> Safety Net/Home Relief | <input type="checkbox"/> Retirement Income from Social Security | <input type="checkbox"/> Social Security Disability Income (SSDI) | <input type="checkbox"/> Supplemental Security Income (SSI) | <input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) | <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) |
| <input type="checkbox"/> Unemployment Insurance | <input type="checkbox"/> VA Non-Service Connected Disability Pension | <input type="checkbox"/> VA Service-Connected Disability Compensation | <input type="checkbox"/> WIC | <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Decline to Answer |

Part VI: Applicant's Health Information

Does the applicant have health insurance? (Select One):

☐ Yes ☐ No ☐ Decline to Answer

If you do not have health insurance, do you want to be contacted by someone else with information about signing up for public health insurance? (Select One)

☐ Yes ☐ No ☐ Decline to Answer

If yes, what kind of health insurance does the applicant have? (Check all that Apply)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Medicare | <input type="checkbox"/> State Children's Health Insurance Program | <input type="checkbox"/> Military Health Care |
| <input type="checkbox"/> Direct-Purchase | <input type="checkbox"/> Employment-Based | <input type="checkbox"/> State Children's Health Insurance for Adults | <input type="checkbox"/> Decline to Answer |

If you would like to be contacted about signing up for public health insurance, what is your preferred method of contact? (Select One):

☐ Email ☐ Phone ☐ US Mail ☐ Via provider ☐ Decline to Answer

Please answer the questions below and provide additional details in the space provided.

Many needs or health challenges can be accommodated and may not limit enrollment in the program.

Does the applicant have any allergies (e.g., food, medication, etc.)? ☐ Yes ☐ No

If Yes: _____



Does the applicant have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the applicant have special health care needs? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes: _____
Does the applicant take medication for any condition or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes: _____
Are there activities the applicant cannot participate in? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes: _____
Please provide any additional health information details:
<input type="checkbox"/> N/A
Please list any accommodation(s) you are requesting for yourself/the applicant:
<input type="checkbox"/> N/A

Part VII: Additional Literacy and Immigrant Services Questions	
Do you want to be contacted by someone with information about child support and arrears programs, and how to make or receive child support payments? <input type="checkbox"/> Yes <input type="checkbox"/> No How would you like to be contacted about this? <input type="checkbox"/> Via this provider <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> U.S Mail	Do you want to be contacted by someone with information about signing up for free financial education or tax assistance programs? <input type="checkbox"/> Yes <input type="checkbox"/> No How would you like to be contacted about this? <input type="checkbox"/> Via this provider <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> U.S Mail
Does the Applicant receive ACS Preventative Services? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Family Member(s) Information				
Name	Date of Birth	Sex of Birth (choose only 1)	Relation to Application	Address
		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> X (not male or female) <input type="checkbox"/> Not Sure		
		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> X (not male or female) <input type="checkbox"/> Not Sure		
		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> X (not male or female) <input type="checkbox"/> Not Sure		
		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> X (not male or female) <input type="checkbox"/> Not Sure		
		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> X (not male or female) <input type="checkbox"/> Not Sure		

Part VIII: Universal Consents and Signatures

Consent for Photography/Videotaping and Use of Original Work

As a participant enrolled in a DYCD-funded program, please be aware that from time to time DYCD and the City of New York, its contracted providers, authorized agents, third-party organizations with which it collaborates, or other government, representatives (collectively, "Authorized Parties") may be present during program activities and special events associated with program services, both at the usual program location and at off-site events. In some cases, they may photograph, videotape, interview or otherwise record participants and their families and friends in these programs. The resulting images, videos, and interviews may be used, with or without the participant's name, in printed and electronic media such as brochures, books, print and email newsletters, DVDs and videos, websites, social media and blogs (collectively, "Media").

I hereby authorize and permit the Authorized Parties, without compensation and without further approval, to photograph and/or record my and my child's image, name, likeness, and the sound of my and my child's voice during DYCD-funded program activities and special events, and I hereby consent to the resulting images, videos and interviews being used, without compensation and without further approval by the Authorized Parties solely for non-profit, non-commercial purposes in any and all Media.

☐ Yes ☐ No

If, in the course of participating in DYCD-funded program activities and special events, any original work such as art, music, choreography, poetry, or prose (collectively, "Original Work") is created by me or my child, I hereby consent to such Original Work being used by the Authorized Parties, without compensation and without further approval, solely for non-profit, non-commercial purposes in any and all Media.

☐ Yes ☐ No

I acknowledge that I am 18 years of age or older.

☐ Yes ☐ No

If you are 18 and over:

Full Name of Participant

Signature

Date



Consent for Emergency Medical Treatment

FOR ADULT PARTICIPANTS (**AGE 18 AND OVER**):

I am enrolled as a participant in a DYCD-funded program. In the event of a medical emergency, I hereby give consent for necessary emergency medical treatment to be obtained on my behalf. I further authorize the emergency contact listed below to be contacted.

☐ Yes ☐ No

Full Name of Participant

Participant's Signature

Date

In the event of a medical emergency, I designate the following person as an emergency contact:

Name of Emergency Contact

Phone Number

Relationship to Me



Consent to Make Referrals and Share Information

The New York City Department of Youth and Community (DYCD) invests in programs and services to help our communities and the people who live here. We want to make sure you know about them and make it easy for you to apply.

Why we need your consent

With it, we can:

- decide if you are eligible for services;
- send you information about DYCD-funded programs and services you can apply for;
- send you information about research activities, focus groups, and surveys related to program improvement;
- share information from your DYCD Participant Application with the programs you apply for; and
- track the results of the services you receive.

What we share

We'll only give information to show you qualify or help you enroll in DYCD-funded programs.

Who sees your information and how we protect it

Only authorized employees at DYCD and the programs DYCD funds can see it.

Please read below, check one of the boxes, and fill in the rest.

I understand that DYCD needs my consent to:

- decide if I am eligible for services;
- send me information about programs and services I can apply for;
- refer me to DYCD-funded programs;
- send me information about research activities, focus groups, and surveys related to program improvement;
- share information from my DYCD Participant Application with the programs I apply for; and
- track the results of the services I receive.

☐ **Yes, I give my consent.**

☐ **No, I do not give my consent.**

Full Name of Participant (please print)

Signature of Participant

Date



Part IX: Additional Literacy & Immigrant Services Consents and Signatures

Consent to Participate

To the best of my knowledge the information above is true. I agree to its verification and understand that falsification may be grounds for termination of service. Information provided may be used by the City of New York to improve City services and access to those services, and to access additional funding.

In order to continue to receive the funding that supports this program, all of the information requested must be collected. If you have any questions, please ask the provider's Program Director.

If applicant is 18 and over:

I acknowledge that I am 18 years of age or older and am authorized to give consent.

☐ Yes ☐ No

Full Name of Participant

Participant's Signature

Date



Part X: Household Income Verification Forms

Community Services Block Grant (CSBG) Program Participant Self-Certification Form

This program is funded by the Community Services Block Grant (CSBG), which is provided by the U.S. Department of Health and Human Services, Administration for Children and Families Office of Community Services. *You must complete this form to document your eligibility to participate in this program.*

Directions: Please find the number of persons in your household, and then **check the box** that contains the amount of annual household income. **INCOME** is defined as the total annual income of all family and non-family members 18+ years old living within the household. All sources of income must be counted from all persons in the household based on anticipated income expected within the next 12 months.

Please check your Income Range based on your household size (for example if there are 5 people in your household, go to HH of 5; if there are 8 in your household go to HH of 8): NOTE: for each additional family member over 8, add \$4,720 per person.

Household	0 – 50%	51 – 75%	76 – 100%	101 – 125%	126% - 200%	201%+
Household of 1:	<input type="checkbox"/> \$0 - \$ 7,530	<input type="checkbox"/> \$ 7,531 - \$11,295	<input type="checkbox"/> \$11,296 - \$15,060	<input type="checkbox"/> \$15,061 - \$18,825	<input type="checkbox"/> \$18,826 - \$30,120	<input type="checkbox"/> \$30,121+
Household of 2:	<input type="checkbox"/> \$0 - \$10,220	<input type="checkbox"/> \$10,221 - \$15,330	<input type="checkbox"/> \$15,331 - \$20,440	<input type="checkbox"/> \$20,441 - \$25,550	<input type="checkbox"/> \$25,551 - \$40,880	<input type="checkbox"/> \$40,881+
Household of 3:	<input type="checkbox"/> \$0 - \$12,910	<input type="checkbox"/> \$12,911 - \$19,365	<input type="checkbox"/> \$19,366 - \$25,820	<input type="checkbox"/> \$25,821 - \$32,275	<input type="checkbox"/> \$32,276 - \$51,640	<input type="checkbox"/> \$51,641+
Household of 4:	<input type="checkbox"/> \$0 - \$15,600	<input type="checkbox"/> \$15,601 - \$23,400	<input type="checkbox"/> \$23,401 - \$31,200	<input type="checkbox"/> \$31,201 - \$39,000	<input type="checkbox"/> \$39,001 - \$62,400	<input type="checkbox"/> \$62,401+
Household of 5:	<input type="checkbox"/> \$0 - \$18,290	<input type="checkbox"/> \$18,291 - \$27,435	<input type="checkbox"/> \$27,436 - \$36,580	<input type="checkbox"/> \$36,581 - \$45,725	<input type="checkbox"/> \$45,726 - \$73,160	<input type="checkbox"/> \$73,161+
Household of 6:	<input type="checkbox"/> \$0 - \$20,980	<input type="checkbox"/> \$20,981 - \$31,470	<input type="checkbox"/> \$31,471 - \$41,960	<input type="checkbox"/> \$41,961 - \$52,450	<input type="checkbox"/> \$52,451 - \$83,920	<input type="checkbox"/> \$83,921+
Household of 7:	<input type="checkbox"/> \$0 - \$23,670	<input type="checkbox"/> \$23,671 - \$35,505	<input type="checkbox"/> \$35,506 - \$47,340	<input type="checkbox"/> \$47,341 - \$59,175	<input type="checkbox"/> \$59,176 - \$94,680	<input type="checkbox"/> \$94,681+
Household of 8:	<input type="checkbox"/> \$0 - \$26,360	<input type="checkbox"/> \$26,361 - \$39,540	<input type="checkbox"/> \$39,541 - \$52,720	<input type="checkbox"/> \$52,721 - \$65,900	<input type="checkbox"/> \$65,901 - \$105,440	<input type="checkbox"/> \$105,441+

I attest that the income information above is true. I understand that falsification of my income is grounds for termination from CSBG program services. I understand that I may be asked to provide income documentation to verify my income. Should my income status change, I hereby agree to promptly notify the program of this change and to submit a revised self-certification form.

Applicant's Name: _____

Applicant Signature: _____ Date: _____

Organization: _____

Intake Specialist/Staff _____ Date: _____