

CSBG Application Checklist:

In order for your application to be considered complete we will need to see the following:

1. A complete Community Service Block Grant application
 - a. EVERYTHING needs to be filled out
 - b. Your signature and date completed
 - c. The gray areas that state “for agency use only” is for the case manager or county manager to complete, you do NOT complete those parts.
 - d. Everything needs to be legible
 - e. And please star (*) or underline which form of contact you would like us to use

2. Signed Grievance Policy

3. Copies of Social Security Cards
 - a. We need these for EVERY person in the Household, not just the adults
 - b. You can bring us copies of the originals OR
 - c. We can accept a copy of the social security numbers from the Department of Human Services (Food Stamp office) OR
 - d. If you have completed a LIHEAP application with SETHRA within the last year, your socials may be on file with us already. Please have us check at time of application.

4. Proof of income for the last 30 days prior to the application date
 - a. This includes the following but not limited to:
 - i. Wages-pay stubs, if no pay stubs we will need to see a signed and dated letter from your employer, with their contact information
 - ii. Child support payments-verified from the courts or Child Support office
 - iii. SSI, Disability, or any other form of Social Security Income, current years benefit letter(s)
 - iv. Temporary Assistance for Needy Families (TANF)/families first
 - v. Unemployment Income and Separation Letter from Employer-for unemployment income we need to see your Maximum Benefit
 - b. If there is an adult in the Household who does not have income we will need to see the following:
 - i. A completed Zero Income form, signed and dated
 - ii. Statement of Support completed by any and all support persons
 - iii. If any adult in the Household has lost their job within the last 30 days we will need to see a copy of their separation letter.

*If we do not receive all of the above within 10 calendar days of your application being taken we will deny the application.

APPLICATION FOR CSBG SERVICES

◆ Community Services Block Grant ◆

For Agency Office Use Only

DATE APPLICATION RECEIVED: _____

PROGRAM END DATE: _____

APPLICATION STATUS: APPROVED DENIED

Applicant Name (first & last): _____ Telephone: _____
 Cell: _____

Current Address: _____ City: _____ State: _____ Zip: _____

County: _____ Email: _____

Mailing Address (If different from Current Address): _____ City: _____ State: _____ Zip: _____

LIST ALL HOUSEHOLD MEMBERS (INCLUDING APPLICANT- Begin with applicant, then spouse, then oldest child, etc.). USE ADDITIONAL PAPER IF YOU NEED MORE SPACE.

NAME (must provide first and last name)	MARITAL STATUS	RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	SEX	(Optional) White, Black, Hispanic, Asian/Pacific Islander, Native American, Native Alaskan, Other - define	EDUCATION LEVEL	VETERAN	DISABLED	CHILD CARE	TANF	FOOD STAMPS	HEALTH INSURANCE	TYPE OF INSURANCE (EMPLOYMENT, STATE, PRIVATE PURCHASE)
1									Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	
2									Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	
3									Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	
4									Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	
5									Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	
6									Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	

CURRENT HOUSING (please check one) OWN RENT SECTION 8 PUBLIC HOUSING AUTHORITY HOMELESS HUD TEMPORARY LIVING WITH FAMILY/FRIENDS

NUTRITION: Does your family experience food insecurity for 1 or more times throughout the month? Y or N Is satisfied through food banks/commodities? Y or N

TRANSPORTATION: Do you have transportation Y or N? Is it reliable? Y or N?

CSBG STATEMENT OF NEED

Please tell us what assistance you need and why on the lines below: (please print)

Services applying for: NUTRITION HEALTH EMERGENCY SERVICES OTHER
 EMPLOYMENT EDUCATION INCOME MANAGEMENT HOUSING

HOUSEHOLD TOTAL INCOME (Below list income information for applicant and all household members). Use additional paper if more space is needed.

▶ **NOTE: YOU MUST ATTACH INCOME DOCUMENTATION FOR EVERY PERSON IN HOUSEHOLD** ◀

NAME	SOURCE OF INCOME <input type="checkbox"/> Employment <input type="checkbox"/> TANF <input type="checkbox"/> Child Support <input type="checkbox"/> Unemployment <input type="checkbox"/> Other	FT / PT	HIRE DATE	GROSS MONTHLY INCOME	IF EMPLOYED, PROVIDE EMPLOYER'S	Is the income reliable?
						Y or N
						Y or N
						Y or N
						Y or N

NAME	SOURCE OF INCOME <input type="checkbox"/> Short-Term Disability <input type="checkbox"/> SS / SSI / VA <input type="checkbox"/> Worker's Compensation	TYPE OF DISABILITY	Permanent / Temporary	GROSS MONTHLY INCOME

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 or receiving aid are either a United States citizen or qualified alien as defined by 8 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 a 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 SERVICES.

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 A 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 Staff Only:

Number in Household:	_____
Total Monthly Income:	_____
Total Annual Income	_____

DATE/TIME TAKEN: _____

Eligibility:

Method of Eligibility: Verification or Self-Declaration

Customer Notification: Verbal or Written

Eligibility Period: ___ / ___ / ___ to ___ / ___ / ___

National Goal: #1 _____ **#6** _____

Goal Was: Achieved Maintained Not Achieved

Explain: _____

INTAKE WORKER SIGNATURE: _____ **DATE:** _____

SIGNATURE OF DETERMINING AGENCY OFFICIAL: _____ **DATE CERTIFIED:** _____

Southeast Tennessee Human Resource Agency

Grievance Policy

SOUTHEAST TENNESSEE HUMAN RESOURCE AGENCY POLICIES do not discriminate against any applicant on the basis of race, color, religion, sex, national origin, disability or political affiliation. It is our policy to cooperate to the fullest extent with applicable rules, regulations, and orders issued by the Tennessee Housing Development Agency. It is our intent that each client be served fairly but in the event of a client feeling they have been treated unfairly, the Agency's grievance policy is listed below:

Any complaints or concerns will first be made to the County Manager in writing with a copy being sent to the Administrative Assistant. All complaints will be responded to within ten (10) working days from the date of the complaint. In the event that the Community Services Director and/or the Community Services Coordinator cannot solve the problem, the Executive Director will receive the concern in writing with a copy of all letters and dates of responses being given no later than thirty (30) working days from the initial complaint. If there is no resolution the complaint will be reviewed by the GRIEVANCE COMMITTEE OF SOUTHEAST TENNESSEE HUMAN RESOURCE AGENCY GOVERNING BOARD. The committee will be given copies of all material relevant to the complaint. After examination, the committee will make determination on the issue raised.

In the event that the Grievance Committee does not reach a satisfactory decision, the Tennessee Department of Human Services will be contacted to render the final decision.

My signature below indicates that SETHRA has explained the grievance procedure and I have received a copy.

Client Signature

Date



Southeast Tennessee Human Resource Agency
 CSBG Program
 Release of Information

Date: ____/____/____ **Client Name:** _____

DOB: ____/____/____ **Social:** ____-____-____

I, _____, hereby authorize the release of my information to Southeast Tennessee Human Resource Agency for the purpose of determining eligibility or for continuing participation for the Family Self Sufficiency Program.

This information may include but is not limited to:

- *Educational Information (Grades, Transcripts, Enrollment Status)*
- *Employment Information (current or past employment history and standing)*
- *Medical Information*
- *Financial (bank accounts, credit reports, etc.)*
- *Any other information provided to other programs or services within this Agency or our sister agencies. (HUD, CSBG, DHS, etc.)*

This information may be shared via fax, telephone, in person, mail, or e-mail. The information obtained will be kept confidential unless we receive a signed Release of Information to release said information.

Signature

Printed Name

Address

City, State

Zip Code

