***Davidson County Community Action, Inc.***
**911 S. Talbert Blvd., P.O. Box 389, Lexington, NC 27293-0389 (336) 249-0234 (voice) 336- 249-2078 (fax)**
**http://communityaction.agency**

# APPLICATION FOR THE ECONOMIC SELF-SUFFICIENCY INITIATIVE

## Thank you for your interest in our services.

Through the federal Community Service Block Grant, administered state-wide by the NC Office of Economic Opportunity, we are able to offer low-income people who live in Davidson County a way to become economically self-sufficient. If you qualify and enroll in this initiative, you will work with a counselor who will help you to set and achieve your goals in employment, education, housing, and more. We can assist you with referrals, help you to budget your money, effectively plan and save for the future, and be an advocate for you each step of the way.

Please read the instructions for completing this Application and fill it out accurately. This will help us to serve you and your family quickly and effectively.

## APPLICATION INSTRUCTIONS

**Read the entire Application thoroughly before completing and submitting.**

**The PDF version of this application can be filled out online.** Please mark the checkboxes or fill in all information for which we ask. Save the filled-out application on your computer, and e-mail the completed form to: davidsoncounty@communityaction.agency. We will contact you for a follow-up appointment in our office if it appears that you may qualify for the Economic Self-sufficiency Initiative.

**Incomplete Applications will not be accepted for review or assistance.**

Part 1 of this document is for Applicant Information. Please provide up-to-date personal information. We need to know if you or anyone in your household has received services from us in the past, how you heard about us, which agency referred you to us, and what types of help you may need now.

Part 2 of the document is for Household Information. We have to collect this information in order to determine your eligibility. Please use care to place the required information in the spaces provided for everyone in your household. Please note that ethnicity and race characteristics are collected for statistical purposes only, and are not criteria used to determine eligibility.

Part 3 of this document is a monthly household budget for expenses. We have to collect this information to help you meet your goals if you are determined to be eligible. Please accurately estimate your current monthly expenses in the spaces provided, with as much detail as possible.

Part 4 of this document is your certification that the information in this Application is true. It also has a waiver so that we may collect more information about you. You must sign this in order for us to determine your eligibility.

Please let us know if you need assistance with this Application or do not understand something—we will be glad to help you.

We use the information that you provide in the Application, along with any further documents requested from you, or any future appointments with us, to determine your eligibility for this program. Your application may be denied for the following reasons:

- Your family income did not meet eligibility guidelines mandated by law: your family income exceeds the limits set by law or regulation.
- You did not provide sufficient information or documentation in order for us to determine your eligibility.
- You did not complete the Application, or keep your follow-up appointment(s), or provide the documents we requested.
- You supplied fraudulent information, or intended to do so.
- You misrepresented your purpose for making application to this program.
- You have not been a resident of Davidson County for at least ninety (90) days, or did not supply documentation proving such residency.
- You (or another family member) were accepted in this program in the past twelve (12) months.
- We may not have funds to enroll you in the program, or we may not have funds to provide you services.

If your application is denied for one of the above reasons, we will inform you in writing, by letter to your mailing address listed in the application, no more than ten (10) days after we determine that you are ineligible for this program. The letter will list the reason(s) for the denial. You will have seven (7) days from the date of the letter to inform us in writing of any information you believe will warrant favorable determination of eligibility.

If you are denied services, upon request, we will hold a hearing within seven (7) days of receiving your request, at which time you will be given the opportunity to present evidence as to why the denial should be over-ruled. We will notify you in writing, within seven (7) days of the hearing, of our decision as to whether or not you are eligible for services.

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***Please print in ink*** **Date:** _____ *For office use only* **Intake Number:**

## Personal Information:

**Applicant Name** _____
*First* *Middle* *Last* *Jr/St/etc*

**Mailing Address** _____

_____

**Physical Address** _____

*Same as Mailing:* _____

**Phone Numbers:**

Home _____ **E-mail Addresses:** _____

Cell _____ _____

Work _____ _____

Message _____ Do you have routine access to the internet? (check one):

Other _____ Yes ❑ No ❑

## Reason for Applying:

Tell us why you are applying for this program:

## Previous Service Information

Has anyone from this household ever received assistance from Davidson County Community Action? (Check One):

Yes ❑ No ❑

If so, when and what type of assistance was given?

## Who referred you to us?

- Family ❑
- Friend ❑
- Internet website ❑
- Phone Book ❑
- Radio ❑
- Television ❑
- Newspaper ❑
- Other Agency (Which one?): ❑

## Which of the following do you need help with right now? (Check all that apply)

*Note: DCCA may not provide all of these services, but this information may help us to provide you with appropriate referrals.*

- ❑ Abuse Intervention
- ❑ Addiction help
- ❑ Budgeting money
- ❑ Credit Counseling
- ❑ Child Care
- ❑ Child Health Needs
- ❑ Clothing
- ❑ Food
- ❑ Food Stamps
- ❑ Home Buyer Help
- ❑ Home Rehab
- ❑ Job Search Help
- ❑ Legal Problems
- ❑ Literacy/GED prep
- ❑ Managing Money
- ❑ Medical Care
- ❑ Mortgage Payment
- ❑ Parenting Skills
- ❑ Rent
- ❑ Senior Health
- ❑ Shelter
- ❑ Tax Filing Help
- ❑ Transportation
- ❑ Utilities
- ❑ Weatherize Home
- ❑ Other (please explain): _____

## Household Members (please complete for everyone in your household including yourself)

| **Name (First, Middle Initial, Last)**<br>*Note: Applicant's Information should be listed on the first line, as the "Head of Household."* | **Date of Birth** | **Age** | **Gender M / F** | **Education Level of Adults: (Inidcate by Letter)**<br>A. Grade 0-8<br>B. 9-12/non-graduate<br>C. High school grad/GED<br>D. 12+ some college<br>E. 2 or 4 yr. college grad<br>F. Post grad<br>*Note: Children should be listed as "N/A"* | **Relationship to you** | **Race/Ethnicity (Indicate by Letter)**<br>A. White<br>B. Black African American<br>C. American Indian/Alaska Native<br>D. Asian<br>E. Native Hawaiian/Other Pacific Islander<br>F.Hispanic/Latino<br>G. Multi-race:<br>(2 or more of the above) | **Characteristics (Check all that apply)**<br>1. Disabled<br>2. Has Health Insurance<br>3. Veteran |
|---|---|---|---|---|---|---|---|
| | | | | | **Head** | | 1. ☐ 2. ☐ 3. ☐ |
| | | | | | | | 1. ☐ 2. ☐ 3. ☐ |
| | | | | | | | 1. ☐ 2. ☐ 3. ☐ |
| | | | | | | | 1. ☐ 2. ☐ 3. ☐ |
| | | | | | | | 1. ☐ 2. ☐ 3. ☐ |
| | | | | | | | 1. ☐ 2. ☐ 3. ☐ |
| | | | | | | | 1. ☐ 2. ☐ 3. ☐ |
| | | | | | | | 1. ☐ 2. ☐ 3. ☐ |
| | | | | | | | 1. ☐ 2. ☐ 3. ☐ |

### Household Income:

| (Check "yes" or "no" for each question) | YES | NO |
|---|---|---|
| **A. Does anyone have income from a job?** | ☐ | ☐ |
| **B. Does anyone have income from Disability?** | ☐ | ☐ |
| **C. Does anyone have income from Social Security?** | ☐ | ☐ |
| **D. Does anyone have income from Work First?** | ☐ | ☐ |
| **E. Does anyone have income from Child Support?** | ☐ | ☐ |
| **F. Does anyone have income from Workers Comp?** | ☐ | ☐ |
| **G. Does anyone have income from a pension?** | ☐ | ☐ |

### Housing:

(Check Most Appropriate Letter)

- **A. Own** ☐
- **B. Rent** ☐
- **C. Homeless** ☐
- **D. Other (please explain):** ☐

### Benefits:

(Answer for each question)

**A. Does your family receive SNAP (Food Stamps)?**

yes ☐ no ☐

**SNAP benefit per month: $** _____

**B Does anyone in your family receive Medicaid?**

yes ☐ no ☐

**Person(s) on Medicaid:**

## Please List Your Monthly Expenses

### Housing

| Category | Monthly Cost |
|---|---|
| Telephone/Cell Phone/Pager | $ |
| Heating Oil/Gas/Wood | $ |
| Homeowner/Renter's Insurance | $ |
| Home Upkeep/Lawn Care | $ |
| Rent/Mortgage | $ |
| Property Taxes | $ |
| Electricity | $ |
| Water Bills | $ |
| **Total:** | $ |

### Food

| Category | Monthly Cost |
|---|---|
| Eating Out | $ |
| Lunches at School | $ |
| Household Supplies | $ |
| Groceries | $ |
| Meat | $ |
| Work (Lunch/Snacks/Coffee) | $ |
| **Total:** | $ |

### Transportation

| Category | Monthly Cost |
|---|---|
| Gas for all vehicles | $ |
| Maintenance (Tires/Oil/Repairs) | $ |
| Auto Insurance/Taxes | $ |
| Car Payment | $ |
| Bus/Carpool/Parking | $ |
| **Total:** | $ |

### Medical

| Category | Monthly Cost |
|---|---|
| Eye Care/Dental Care | $ |
| Doctor Visits | $ |
| Health Insurance | $ |
| Prescriptions | $ |
| **Total:** | $ |

### Child Care

| Category | Monthly Cost |
|---|---|
| Child Support/Alimony | $ |
| Childcare Center/Sitter | $ |
| **Total:** | $ |
| **Total This Column:** | $ |

Total of both columns

**$**

### Education

| Category | Monthly Cost |
|---|---|
| Tuition/Loans | $ |
| School Books/Supplies | $ |
| **Total:** | $ |

### Clothing

| Category | Monthly Cost |
|---|---|
| Purchases | $ |
| Laundry/Dry Cleaning | $ |
| **Total:** | $ |

### Entertainment

| Category | Monthly Cost |
|---|---|
| Cable TV/Satellite | $ |
| Vacations/Weekend Travel | $ |
| Magazines/Newspapers/Books | $ |
| Movies/Videos/Rentals/Music | $ |
| Sports/Gym Fees/Hobbies | $ |
| **Total:** | $ |

### Miscellaneous

| Category | Monthly Cost |
|---|---|
| Gifts (holidays/Birthdays) | $ |
| Other (Toiletries, etc) | $ |
| Contributions (Church/Charities) | $ |
| Pet Care | $ |
| Life Insurance | $ |
| Alcohol | $ |
| Beauty Shop/Barber Shop | $ |
| Tobacco | $ |
| **Total:** | $ |

### Business Expenses

| Category | Monthly Cost |
|---|---|
| Recurring Costs | $ |
| One Time Cost | $ |
| **Total:** | $ |

### Financial Expenses

| Category | Monthly Cost |
|---|---|
| Saving | $ |
| Debt Payment | $ |
| Banking Fees/Postage | $ |
| **Total:** | $ |
| **Total this Column:** | $ |

**Certification and Waiver of Privacy Rights**

I certify to the best of my knowledge that the total annual income for my family is $ _____.

I further certify that all information provided herein is true to the best of my knowledge. I am aware that this information is subject to review and verification, and I may have to provide documents to support it. I am aware that I may be denied assistance if I am found ineligible or if I do not meet program requirements. I am aware that I may be prosecuted if I have knowingly given false information in order to receive assistance. I have been notified of my right to appeal any denial of service or assistance for which I may be eligible. I hereby grant permission and authorize any employer, utility company, fuel company, Veteran's Administration, local Department of Social Services, Social Security Administration, and other public and/or private institution to share information regarding my past and/or present financial situation in order to determine whether or not I am eligible for services. I allow release of confidential information contained herein for purposes of verification. I understand that any personal information I provide will be held in confidence in order to protect my privacy.

| | |
|---|---|
| **Applicant Signature** **Date** | 10A NCAC97C.0107 (e) (2): "The grant reciepient [DCCA] must make a reasonable number of spot checks of family units to verify income given in the self-declaration statements. In making the spot checks, the grant recipient should contact appropriate sources, such as employer, local Department of Social Services, Social Security Administration, or other appropriate sources to obtain written documentation. This documentation should be attached to self-declaration statement." |
| **Interviewer's Signature** **Date** | |

**Case Manager Notes:**

| | |
|---|---|
| Office use only: | **90 Day Look Back Date:** |
| | _____ |