SAN BENITO COUNTY

TRACEY BELTON
DIRECTOR

Health & Human Services Agency
COMMUNITY SERVICES & WORKFORCE DEVELOPMENT
1161 SAN FELIPE ROAD, BUILDING B • HOLLISTER, CA 95023
(831) 637-9293 • FAX (831) 634-0785

COMMUNITY DEVELOPMENT BLOCK GRANT (CDBG) CV- 1 UTILITY ASSISTANCE CHECKLIST

Mark all types of assistance requested:

__Water/Sewer __Waste/Garbage __Energy (Gas/Electric)

Please provide all documents within 10 days.

	Completed and Signed Application
	Current/Past due utilities statement(s) *must have complete front page & all additional pages of statement*
	Proof of income for the past **30** days from all sources and household members: (SSI, SDI, Employment, Unemployment, Worker's Comp, Child Support, Alimony, etc.) if anyone 18 or over has no income, they must submit a self-certification form.
	Proof of Residency – must indicate a minimum of 30 days within San Benito County
	Photo ID for all adults 18 and over in the household
	Social Security cards for all members in the household (as applicable)
	Birth Certificates for all members in the household or Affidavit

Sign and Date all forms

	Duplication of Benefits Affidavit		Americans with Disabilities Form
	COVID 19 Statement of Need		Demographics Form
	Release of Information Authorization/Nepotism Form		Customer Satisfaction Letter
	Fair Hearing/Appeals Process Summary		

Income Guidelines

Family Size	1	2	3	4	5	6	7	8
Income Limit	$54,700	$62,500	$70,300	$78,100	$84,350	$90,600	$96,850	$103,100

Printed Name (head of household) **Last 4 # of SSN**

Ending Poverty by Empowering People
To find out about other low-income services, please visit our website at: www.sbccab.com

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COMMUNITY DEVELOPMENT BLOCK GRANT (CDBG) CV- 1 UTILITY ASSISTANCE APPLICATION

Please complete one form PER HOUSEHOLD. The adult head of household must sign & date.

Name:____

Address:____

Phone:___________________________________Message Phone:_________________

Email:____

Type of assistance requested. Please mark all those applying for:

___Water/Sewer ___Garbage/Waste ____Energy (Gas/Electric)

PART 1: ELIGIBILITY ***COVID-19 Hardship Documentation***

Have you lived in San Benito County 30 days or more? _____YES _____NO

PART II: Household Information: Please include all members in the household:

How many total members live in your household? 1 2 3 4 5 6 7 8

How many are under the age of 18? 1 2 3 4 5 6 7 8

PART III: Annual Income: Report all current income (wages, child support, SSI, SSA, Unemployment, pension, etc.) received in the past 30 days. DO NOT INCLUDE IRS Economic Impact Payments (stimulus checks), Federal Pandemic Unemployment Compensation (the additional $600 per week) income. **** Verification Required**

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What is your/your family current source of income?

Family Member	Income Source	Monthly Income	Total Income Last 30 days**

Utility Information:

Are you behind with Utility bills, such as gas/electric, water/sewer, or waste/garbage?

____YES ____No

If you are behind on your utilities, please identify service:

Utility	Months Behind	Past Due Amount	Total Amount Owed

PART IV: Applicant Certification: I certify that the information given on this form is true and accurate to the best of my knowledge. I am aware that there are penalties for willfully and knowingly giving false information on an application for Federal Funds, which may include immediate repayment of all Federal Funds received and/or prosecution under the law. I attest, that all the answers, information, and documentation I provide for the application for this one-time disaster relief assistance are true and accurate to the best of my knowledge.

Your application is not complete until you submit proof of income and other eligibility documentation.

Participant Signature Date

CSWD Signature Date

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COMMUNITY DEVELOPMENT BLOCK GRANT (CDBG) CV-1 UTILITY ASSISTANCE

DUPLICATION OF BENEFITS AFFIDAVIT ("Affidavit")

Name: ____

____
Address **City** **Zip Code**

Please check one: _____City of Hollister _____San Benito County _____San Juan Bautista

I/We understand that the amount of assistance received by I/We from agency listed above, must be reduced by the amount of Duplicate Assistance received or that will be received for the Need, from other sources (such as, FEMA, SBA, the Red Cross, the City, homeowner's insurance, etc.) for the same purpose.

Therefore, I/We understand if I/We receive assistance from a source other than agency listed above, (such as, FEMA, SBA, the Red Cross, the City, homeowner's insurance, etc.) for the Need for the same purpose, I/We must repay the assistance received from agency listed above.

I/We certify under State and Federal penalties for perjury and fraud that the information provided above is true and accurate and acknowledge that repayment of all assistance received by Me/Us from agency listed above, payment of fines and/or imprisonment may be required in the event that I/We provide false, incomplete or misleading information in this Affidavit or during the rest of this process.

By executing this Affidavit, Applicant(s) knowledge and understand that Title 18 United States Code Section 1001: (1) makes it a violation of federal law for a person to knowingly and willfully (a) falsify, conceal, or cover up a material fact; (b) make any materially false, fictitious, or fraudulent statement or representation; OR (c) make or use any false writing or document knowing it contains a materially false, fictitious, or fraudulent statement or representation, to any branch of the United States Government; and (2) requires a fine, imprisonment for not more than (5) years, or both, which may be ruled a felony, for any violation of such Section.

Participant____

Signature of Participant______________________________ Date______________

Participant____

Signature of Participant______________________________ Date______________

7-30-21

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COMMUNITY DEVELOPMENT BLOCK GRANT (CDBG) CV-1 UTILITY ASSISTANCE COVID-19 STATEMENT OF NEEDS

Please explain how the COVID-19 Pandemic has affected you/your family in such a manner that you are seeking assistance:

□ Individuals who have acquired COVID-19 but do not required hospitalization

□ Individuals who have been exposed to COVID-19

□ Individuals who are "High Risk" for COVID-19 such as people over 65 or have underlying medical conditions. For example, people with chronic lung disease, asthma, serious heart conditions, liver disease, diabetes, chronic kidney disease undergoing dialysis, severe obesity, and immunocompromised. Many conditions can cause a person to be immunocompromised such as cancer treatments, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, prolonged use of corticosteroids and other immune weakening medications.

□ Unable to work due to care of family member or caring for children who are distance learners

□ Reduction of work hours due to COVID-19

□ Loss of employment due to COVID-19

□ Other, please describe: ____

I attest that the information stated above is true and accurate, and I understand that the above information if misrepresented, or incomplete, may be grounds for immediate termination from the program(s), and/or penalties as specified by law.

____
Applicant's Signature | Date

CA
____
Address | City | State | Zip Code

____
Signature of CSWD Staff | Date

7.30.21

PLEASE READ CAREFULLY AND FILL IN ALL GREY AREAS OF THIS FORM ONLY

A. RELEASE OF INFORMATION AUTHORIZATION

______ Initial

The use of CSWD funds is limited to eligible applicants. CSWD regulations require verification of income/benefits and other information pertinent to the determination of eligibility for the programs. No applicant can be determined eligible or ineligible until all eligibility documentation is received by the Department of Community Services & Workforce Development.

______ Initial

By signing this release form, I am hereby giving my permission to the Department of Community Services & Workforce Development to verify the accuracy of the information that I have provided which includes; income and benefits received, date of birth, citizenship, county residence, social security number, selective service registration, existence of family members, legal status (prior convictions, parole, probation), employment, education and other information required for purposes of determining my eligibility.

______ Initial

I am also giving my permission to the Department of Community Services & Workforce Development to release information contained in my file to other social service agencies. All information and paperwork received during the eligibility determination process is maintained by the CSWD office and will not be returned to me. I understand that falsification of any item is grounds for termination from the CSWD program and may result in action to recover any moneys paid to me while participating.

B. NEPOTISM STATEMENT

1. Is a member of your immediate family (spouse, parent, child, brother, sister, uncle, aunt, niece, nephew, in law, step-parent or step-child) an elected City or County official, or member of the Community Services & Workforce Development Board? If yes, what is his/her name, elected title, and relationship to you? ☐ Yes ☐ No

   If yes, what is his/her name, elected title, and relationship to you?

   ______

2. Is a member of your immediate family (spouse, parent, child, brother, sister, uncle, aunt, niece, nephew, in law, step-parents or step-child) an employee of the City, County or a subcontractor of the San Benito county Community Services & Workforce Development? If yes, what are his/her name, position, and relationship to you? ☐ Yes ☐ No

   If yes, what is his/her name, elected title, and relationship to you?

   ______

☐ 3. **To the best of my knowledge, I have no relatives of any degree, working for San Benito County.**

______
APPLICANT SIGNATURE

______ ______
PRINT NAME DATE

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FAVOR DE LEER CUIDADOSAMENTE y COMPLETE LAS AREAS EN GRIS SOLAMENTE

FAIR HEARING/ APPEALS PROCESS SUMMARY FORM

The San Benito County Community Services & Workforce Development has agreed to comply with Title 22 of the California Administrative Code, Section 100751, as amended which sets forth elements to be included in client benefit denial appeal procedures.

You are hereby advised that should you be denied assistance for which you have applied, and for which you have submitted a complete application and eligibility documentation as required, you may appeal that decision within twenty (20) days from receiving notice of denial.

Within five (5) working days of receipt of your appeal, the Community Services & Workforce Development shall conduct a Fair Hearing at the local level. Should your complaint not be resolved at the local level, you may appeal to Grantor/Funding source for which you have been denied. The Community Services & Workforce Development shall provide proper forms and guidance in making your appeal.

You may withdraw your request for appeal for an administrative hearing at any time during the appeals process by tending written or oral notice. Where oral notice is given, the parties shall confirm such notice in writing.

POLICY FOR GRIEVANCES BY CLIENT

Any client who has been denied services by this agency may file a grievance with the Director of the agency. Each employee will inform the participants of their appropriate grievance procedure and issue those procedures.

Upon receipt of a grievance, the grievance will be passed to the appropriate Deputy Director who will meet with the Director and determine the appropriate course of action as required by the funding source.

The information contained in your file is confidential and will not be disclosed to anyone without your written permission. Your file becomes the property of the San Benito County Department of Community Services & Workforce Development.

PROCESO DE AUDENCIA/APELACION

La Agencia de Servicios de la Comunidad y Desarrollo de Trabajadores Unidos del Condado de San Benito ha aceptado cumplir con los reglamentos de TITULO 22 del Código Administrativo de California, Sección 1007551 enmendado, que indica los elementos necesarios para que el proceso de una apelación si es que los beneficios son negados al cliente.

De aquí en adelante queda usted informado (a) de que si a usted se le niega la asistencia por la cual usted aplico, y por la cual usted sometió una solicitud completa con documentación de elegibilidad que se requirió, usted tiene el derecho de apelar esta decisión dentro de veinte (20) días después que usted haya recibido un aviso de negación.

Dentro de cinco (5) días después de que la Acción de La Comunidad haya recibido su apelación, se llevara a cabo una audiencia a nivel local. Si su apelación no se resuelve al nivel local, usted tiene el derecho de someter una apelación a la fuente de los fondos federales de los cuales a usted se le negó los servicios. La agencia de Acción de la Comunidad le dará las formas necesarias para su apelación. Usted podrá referir su apelación por aviso escrito u oral, se confirmará el aviso por escrito.

POLIZA DE QUEJA FORMAL POR PARTE DEL CLIENTE

El cliente que se le ha negado servicios de la Agencia puede someter una queja formal con el Director de la agencia. Cada empleado le informara al participante del proceso apropiado para someter una queja formal.

En cuanto se reciba una queja formal, la queja pasará al asistente del director que se reunirá con el Director para determinar la acción apropiada como es requerida por la fuente de los fondos federales.

La información que contiene su archivo es confidencial, y no será revelado a nadie sin su permiso por escrito. Su archivo se convierte propiedad de la Agencia de Servicios de la Comunidad y Desarrollo de Trabajadores Unidos.

______________________________ ______________________________
Client Signature/*Firma del Cliente* Date/*Fecha*

______________________________ ______________________________
Spouse's Signature/*Firma del Cliente* Date/*Fecha*

______________________________ ______________________________
CSWD Staff Signature Date

Rev 09.2020

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AMERICANS WITH DISABILITIES ACT (ADA)

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____

Client Signature   Date

____

CSWD Staff Signature   Date

LEY DE ESTADOUNIDENSES CON DISCAPACIDADES (ADA)

La División de Servicios Comunitarios y Desarrollo Laboral (CSWD) de la Agencia de Salud y Servicios Humanos (HHSA) es un empleador/programa de igualdad de oportunidades. El cumple con la Ley de Estadounidenses con Discapacidades (ADA) al asegurar que las ayudas auxiliares para los servicios están disponibles a petición de las personas con discapacidades. Las personas con discapacidad auditiva pueden llamar al teléfono TDD/TTY (831)637-3265. Las personas que requieran cualquier necesidad especial de acceso a la oficina de CSWD deben llamar al (831)637-9293 al menos cinco días hábiles antes de la fecha necesaria para organizar las adaptaciones especiales. Condado de San Benito

____

Firma del Cliente   Fecha

____

Firm CSWD   Fecha

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COMMUNITY DEVELOPMENT BLOCK GRANT (CDBG) CV-1 UTILITY ASSISTANCE DEMOGRAPHICS

This information is mandatory for state reporting:

Household Demographic Data (Select all that Applies)

___Single Parent/Female ___Single Parent/Male ___Disabled

___Veteran ___Senior (60+) ___Single (Under 60)

___Related/Single Parent ___Related/Two Parent ___Other: __________

Ethnicity Categories for Federally Funded Program Applications: This section is voluntary

RACE

	White		American Indian or Alaska Native AND White
	Black/African American		Asian AND White
	Asian		Black/African American AND White
	American Indian or Alaska Native		American Indian/Alaska Native AND Black/African American
	Native Hawaiian or Other Pacific Islander		Other:

Ethnicity: **Hispanic or Latino** **___YES** **___NO**

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Date

Dear Applicant,
Estimado (a) Aplicante,

We welcome the opportunity to serve you and pride ourselves on being customer oriented and focus all efforts on customer satisfaction.
Les damos la bienvenida a la oportunidad de ayudarles y tenemos orgullo de enfocar todos nuestros esfuerzos a la satisfacción de nuestros clientes.

If you received great or outstanding service, please tell all your friends and relatives.
Si usted recibió buen servicio haga el favor de decirles a todos sus amigos y parientes.

If you feel the service, you received is/was poor, then please tell me. You do not need to give me your name just your concern.
Si usted siente que recibió mal o pobre servicio haga el favor de comunicármelo a mí. No me tiene que dar su nombre nomás su queja.

Sincerely,
Sinceramente,

ENRIQUE ARREOLA
Deputy Director, CSWD

Received a copy on ______________ ______________
Recibí una copia de esta forma Date/*Fecha* Initials/*Iniciales*