SAN BENITO COUNTY
Health & Human Services Agency
TRACEY BELTON
DIRECTOR
COMMUNITY SERVICES & WORKFORCE DEVELOPMENT
1131 SAN FELIPE ROAD, Suite 107 • HOLLISTER, CA 95023
(831) 637-9293 • FAX (831) 634-0785 • www.sbccab.com

COMMUNITY SERVICE BLOCK GRANT (CSBG) CARES
DREAM CATCHER APPLICATION

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

Date:			
Who Referred you?			
Name:			
Address:			
Phone:		Message Phone:	
Email:			
Gender: ☐ Female ☐ Male			
Birthdate:		Driver's License:	
Other Names Used:			

Household Demographics

Household Type:

☐ Single Parent-Female
☐ Single Parent-Male
☐ 2 Parent Household
☐ 2 or More Adults
☐ Extended Household
☐ Mixed Adults with Children
☐ Grandparents raising the child
☐ Other: _____

Household Size: _____

Additional Household Members*:*

First and Last Name	Gender	Date of Birth	Relationship
	☐ Female ☐ Male		
	☐ Female ☐ Male		
	☐ Female ☐ Male		
	☐ Female ☐ Male		
	☐ Female ☐ Male		
	☐ Female ☐ Male		
	☐ Female ☐ Male		
	☐ Female ☐ Male		
	☐ Female ☐ Male		

Applicant Demographics

Education		**Marital Status**	
☐ 0-8	☐ 9-12/ Non-Graduate	☐ Single	☐ Married
☐ High School Graduate	☐ GED	☐ Domestic Partner	☐ Divorced
☐ 12+ Some Post-Secondary	☐ 2- or 4-Years College Graduate	☐ Widowed	☐ Separated

Primary Language:	**Citizen:**
☐ English	☐ Citizen
☐ Spanish	☐ Legal Alien-Eligible
☐ ASL (American Sign Language)	☐ Legal Alien-Ineligible
☐ Other: _____	☐ Undocumented

Disability Status: ☐ YES ☐ NO ☐ Unspecified

Ethnicity: Select one: ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Race: Select One:

☐ Caucasian	☐ Asian & White	☐ Black/African American & White
☐ Black/African American	☐ Native Hawaiian/Other Pacific Islander	☐ Other: Multi-Racial:
☐ Asian	☐ American Indian/Alaskan Native & White	_____

Release of Information

RELEASE OF INFORMATION AUTHORIZATION

A. 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.

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.

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.*

RELEASE OF INFORMATION - PART II

B. **NEPOTISM**: Is a member of your immediate family an elected City or County official, or a member of the Community Action Board or the Workforce Development Board? (This could be a spouse, parent, child, brother, sister, uncle, aunt, niece, nephew, in law, step parent or step child).

☐ **NO** If yes, what is his/her name, elected title, and relationship to you?

C. Is a member of your immediate family an employee of the City, County or a subcontractor of the San Benito County Community Services & Workforce Development? (This could be a spouse, parent, child, brother, sister, uncle, aunt, niece, nephew, in law, step parents or step child)

☐ **NO** If yes, what is his/her name, job title, and relationship to you?

D. FAIR HEARING/APPEALS PROCESS SUMMARY FORM: I hereby acknowledge receipt of a Fair Hearing/Appeals Process Summary Form.

PRINT NAME

SOCIAL SECURITY NUMBER

Applicant Signature

DATE

FAIR HEARING & APPEALS

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.

PRINT NAME

Last 4 numbers of SOCIAL SECURITY NUMBER

Applicant Signature

DATE

Income (Last 30 Days) **Verification Required

Annual Income Report all current income (wages, child support, SSI, Unemployment, pension) received in the past 30 days.

What is your/your family current source of income?

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

Income Amount: $_____

Income Interval		
☐ Bi-Monthly ☐ Bi-Weekly	☐ Daily ☐ Monthly ☐ One Time	☐ Quarterly ☐ Twice a month ☐ Weekly

Applicant Certification I certify that the information given on this form in 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.

Client Signature/*Firma del Solicitante* Date/*Fecha*

SAVE