Department of Youth & Community Development

Applicant Registration Form

Intake Date _____ **First Name** _____ **Initial** _____ **Last Name** _____

Social Security Number _____-_____-_____ **Date of Birth** _____ **Gender** ☐ Male ☐ Female

Primary Address _____ **Apt** _____

City _____ **State** _____ **Zip** _____

Home Phone _____--_____--_____ **Mobile Phone** _____--_____--_____

Email Address _____ **Preferred Method of Contact** ☐ Email ☐ Phone ☐ US Mail ☐

Race (check all that apply)

☐ Black or African American ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander

☐ Asian ☐ White ☐ Other

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Country of Origin? _____

Are you a parent? ☐ Yes ☐ No **Are you a Veteran?** ☐ Yes ☐ No

Disabled? ☐ Yes ☐ No **If yes, are you Homebound?** ☐ Yes ☐ No

Offender/Criminal Justice System-involved? ☐ Yes ☐ No

In Foster Care? ☐ Yes ☐ No **ACS Preventative Services?** ☐ Yes ☐ No

SNAP (Food Stamps)? ☐ Yes ☐ No **Medicaid?** ☐ Yes ☐ No

Housing ☐ Own ☐ Rent ☐ Shelter ☐ Homeless ☐ Other **Do you live in NYCHA Housing?** ☐ Yes ☐ No

Are you or is any member of the household (0 – 64 years of age) covered by Medicaid, Child Health Plus, or private medical insurance? ☐ Yes ☐ No

If no, have you asked this provider to assist you in signing up for health insurance programs? ☐ Yes ☐ No

If no, do you want to be contacted by someone else with information about signing up for public health insurance programs? ☐ Yes ☐ No

How would you like to be contacted about this issue? ☐ Via this provider ☐ Email ☐ Phone ☐ US Mail

Do you want to be contacted by someone else with information about signing up for free financial education or tax assistance programs? ☐ Yes ☐ No

How would you like to be contacted about this issue? ☐ Via this provider ☐ Email ☐ Phone ☐ US Mail

Do you want to be contacted by someone else with information about child support and arrears programs, and how to make or receive child support payments? ☐ Yes ☐ No

How would you like to be contacted about this issue? ☐ Via this provider ☐ Email ☐ Phone ☐ US Mail

English Proficient? ☐ Yes ☐ No **English Language Learner (ELL)?** ☐ Yes ☐ No

Preferred Language _____

Education (enter/check Last Grade Completed)

Enter Grade 0-11 _____ ☐ 12 High School Graduate ☐ HSE/GED ☐ 12+ Some Post-Secondary

☐ 2 or 4 year College Degree ☐ In school – full time ☐ In school – part time ☐ Out of school

If in school, is your program ☐ Trade School ☐ Academic

Work History Employed? ☐ Yes, Full-Time ☐ Yes, Part-Time ☐ No, In school ☐ No, retired

☐ No, Out of work less than 26 weeks ☐ No, out of work 26-52 weeks ☐ No, out of work greater than 52 weeks **Status** _____

Is your resume on file with this provider? ☐ Yes ☐ No

Household / Family Type

☐ Single Parent – Female ☐ Single Parent – Male ☐ Two Parent Household

☐ 2 Adults – No children ☐ Single Person ☐ Other

Family Size (check Number of people in household)

☐ One ☐ Two ☐ Three ☐ Four ☐ Five ☐ Six ☐ Seven ☐ Eight or More

Household 12-month Gross Income $ _____ **Individual Income $** _____

Sources of Income ☐ TANF ☐ SSI ☐ Social Security ☐ General Assistance

(Check all apply) ☐ Pension ☐ Employment ☐ Unemployment Insurance Benefits ☐ Public Assistance ☐ Other

Student Information (if applicable)

Individualized Educational Program (IEP) ☐ Yes ☐ No

Student ID number (OSIS# for Public School students) _____

School Name _____ **School Address** _____

City _____ **State** _____ **Zip** _____

Emergency Contact Info First Name _____ **Initial** _____ **Last Name** _____

Gender ☐ Male ☐ Female **Relationship to Participant** _____

Home Phone ___ -- ___ -- ____ **Mobile Phone** ___ -- ___ -- ____

Email Address _____

To the best of my knowledge the information above is true. I agree to its verification and understand that falsification is grounds for termination from Community Services Block Grant (**CSBG)-funded programs of service.**

Applicant: _____ Date: _____

As parent/guardian, I give permission for my child to register and participate in the _____ program and to complete anonymous surveys seeking participant feedback of the program.

Parent/guardian: _____ Date: _____
(Signature required if applicant is under the age of 18)

Organization: _____

Intake Specialist/Staff_____ Date: _____

In order to continue to receive the federal funds that support this program, all of the information requested must be collected. If you have any questions, please ask the provider's program director.

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 United States Department of Health and Human Services, Administration for Children and Families Office of Community Services, via the New York State Department of State, Division 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 Household of 5; if there are 8 or more in your household go to Household of 8):

Household of 1:	☐ $0	☐ $1 - $6,380	☐ $6,381 - $12,760	☐ $12,761 - $15,950	☐ $15,951 - $19,140	☐ $19,141 -$25,520	☐ $25,521 +
Household of 2:	☐ $0	☐ $1 - $8,620	☐ $8,621 - $17,240	☐ $17,241 - $21,550	☐ $21,551 - $25,860	☐ $25,861 - $34,480	☐ $34,481 +
Household of 3:	☐ $0	☐ $1 - $10,860	☐ $10,861 - $21,720	☐ $21,721 - $27,150	☐ $27,151 - $32,580	☐ $32,581 - $43,440	☐ $43,441 +
Household of 4:	☐ $0	☐ $1 - $13,100	☐ $13,101 - $26,200	☐ $26,201 - $32,750	☐ $32,751 - $39,300	☐ $39,301 - $52,400	☐ $52,401 +
Household of 5:	☐ $0	☐ $1 - $15,340	☐ $15,341 - $30,680	☐ $30,681 - $38,350	☐ $38,351 - $46,020	☐ $46,021 -$61,360	☐ $61,361 +
Household of 6:	☐ $0	☐ $1 - $17,580	☐ $17,584 - $35,160	☐ $35,161 - $43,950	☐ $43,951 - $52,740	☐ $52,741 - $70,320	☐ $70,321 +
Household of 7:	☐ $0	☐ $1 - $19,820	☐ $19,821 - $39,640	☐ $39,641 - $49,550	☐ $49,551 - $59,460	☐ $59,461 - $79,280	☐ $79,281 +
Household of 8:	☐ $0	☐ $1 - $22,060	☐ $22,061 - $44,120	☐ $44,121 - $55,150	☐ $55,151 - $66,180	☐ $66,181 - $88,240	☐ $88,241 +

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 Name_____

Applicant Signature_____ **Date:** _____

Parent/guardian: _____ **Date:** _____
(Signature required if applicant is under the age of 18)

Organization: _____

Intake Specialist/Staff_____ **Date:** _____