



Community Council of South Central Texas, Inc. Community Services Program Application

Date/Time Received

PLEASE NOTE: Incomplete applications will not be processed!

- Applications will be accepted by email, fax, mail, or drop off and will be processed according to priority and date received.
- **Please note it can take anywhere from 4 to 8 weeks to process complete applications and in some cases may take longer depending on the time of the year and the number of applications already in process.**
- **You are still responsible to pay your bill until your application is processed and you are notified of outcome.**
- This application is for screening purposes only and does not guarantee your eligibility to receive services. Payments are made within **45 days** from the date of the voucher and are subject to availability of funds.

REQUIRED DOCUMENTS FOR ALL PROGRAMS

- ❖ Completed application including all required documents.
- ❖ Social security cards for all household members
- ❖ **Proof of ALL income FOR THE PAST 30 DAYS for every household member 18 years or older**, who works or receives assistance. (Check stubs, Social Security/SSI, award letters including minor children receiving any type of SS benefit included) Letters must be from Social Security Administration and must reference or be dated for the current year, VA letter, unemployment, TANF letter, retirement, pension, child support, etc.
- ❖ **If any household member 18 or over is NOT receiving any income, you must complete the attached Declaration of Income Statement.**

ELECTRIC, GAS & WATER ASSISTANCE, REQUIRES ALL ABOVE DOCUMENTS AND THE FOLLOWING

- ❖ **Proof of Citizenship and identity for ALL household members. NO EXCEPTIONS!**

| | |
|--|--|
| ONE OF THESE: Passport, Certificate of Naturalization, Cert. Of US Citizenship, Cert. of US Tribal Enrollment w/photo | |
| OR | |

| | |
|---|--|
| ONE OF THESE: State Issue Driver's License, Military Card, State Issue ID Card, State Offender Card, Current School ID | AND ONE OF THESE: Certified Copy - State Issued Birth Certificate (Not Footprint Record), Permanent Resident Card Non-Immigrant Cards Refugee Card. |
|---|--|

- ❖ **A 12 month billing history** from each of your energy providers (**ELECTRIC, WATER, NATURAL GAS AND/OR PROPANE**) NOTE: if you less than 12 months in your home, provide history for as many months as possible.
- ❖ **Your current and past due bills for electric** and a disconnect notice if applicable.
- ❖ **Your past due water/wastewater bill and disconnect notice** (at this time, we can only assist with water and wastewater if you are in danger of disconnection. or have been disconnected)

CCSCT-CS COMPLAINT POLICY

Clients or partners who wish to complain about staff treatment, application status or any other complaint are advised to contact: Carol Delgado, CCAP, NCRI, Program Director by phone at 830-767-2019, or email cdelgado@ccsct.org. The alternate contact for complaints is Belinda Lacey, CCAP, NCRI, Compliance Manager at phone number 830-625-6268 or email blacey@ccsct.org. Either Carol Delgado, or Belinda Lacey will conduct an investigation within 10 days and will follow up with the person submitting the complaint once the investigation is complete. If the complaint is in regards to a denial due to income, the client will be reminded of the appeals process as outlined in the denial form.



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| |
|---|
| OFFICE USE ONLY! |
| Date/Time Received ____ / ____ / ____ |
| Priority Elderly / Disabled / Child 5 or younger |

| | | | | | | |
|--|---|--|--|--|--|---|
| HEAD OF HOUSEHOLD INFORMATION | | | | | | |
| First Name: | | Last Name: | | Middle Initial: | | |
| Date of birth: | | SS #: | | Contact # or Cell Phone: | | |
| Home Phone: | | Work Phone: | | Housing Type: (circle) Rent or Own | | |
| Residential Address: | | | | Apt.#: | | |
| City, State, Zip | | | | County: | | |
| Mailing Address (if different): | | | | Apt.#: | | |
| City, State, Zip | | | | | | |
| Email Address: | | | | | | |
| Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other | Race <input type="checkbox"/> African American /Black <input type="checkbox"/> American Indian <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Multi-Race | | Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic | Education <input type="checkbox"/> 0-8 <input type="checkbox"/> 9-12 <input type="checkbox"/> HS Grad / GED <input type="checkbox"/> 12+ college <input type="checkbox"/> 2/4 yr Grad | Military Status <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> N/A | Seasonal Work <input type="checkbox"/> Farmer <input type="checkbox"/> Migrant Work <input type="checkbox"/> Seasonal Work <input type="checkbox"/> Other <input type="checkbox"/> None |
| Relationship to Applicant <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other | | Work Status 18 or over <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Unemployed 6 month + <input type="checkbox"/> Unemployed less than 6 mos. | | <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Minor under 18 | Health Insurance <input type="checkbox"/> Direct purchase <input type="checkbox"/> Employment based <input type="checkbox"/> Military Health Care <input type="checkbox"/> Adults State Health Ins. | <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP <input type="checkbox"/> None |
| Other income received <input type="checkbox"/> Child Support <input type="checkbox"/> SS Disability <input type="checkbox"/> SS Retirement <input type="checkbox"/> SSI <input type="checkbox"/> Pension <input type="checkbox"/> Private Disability <input type="checkbox"/> TANF | | | <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Alimony/Spousal Support <input type="checkbox"/> VA Service Connected Disability <input type="checkbox"/> VA Non-Service Connected Dis. <input type="checkbox"/> Unemployment Benefit <input type="checkbox"/> None | Receive Non-Cash Benefits <input type="checkbox"/> Affordable Care Act Subsidy <input type="checkbox"/> Childcare Voucher <input type="checkbox"/> Housing Choice Voucher <input type="checkbox"/> Public Housing | | <input type="checkbox"/> HUD-VASH <input type="checkbox"/> SNAP (food stamps) <input type="checkbox"/> WIC <input type="checkbox"/> None |

By signing below I acknowledge that I have read, understand and agree with the entire CCSCT application:
I certify that the information on this application is correct and I also understand that receipt of assistance through misrepresentation or fraud is punishable by fine or imprisonment.

Applicant signature _____

Date _____

Staff Signature _____

Date _____

Please complete the following pages for all other household member(s). You **MUST** answer **ALL** questions.

Please ask for additional pages if you have more than 3 people in the home.

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OTHER HOUSEHOLD MEMBERS

| | | | | | |
|--|--|---|--|---|---|
| Household Member First Name: | | Last Name: | | Middle Initial: | |
| Date of birth: | | SS #: | | | |
| Gender | Race | Ethnicity | Education | Military Status | Seasonal Work |
| <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other | <input type="checkbox"/> African American /Black <input type="checkbox"/> American Indian <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Multi-Race | <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic | <input type="checkbox"/> 0-8 <input type="checkbox"/> 9-12 <input type="checkbox"/> HS Grad / GED <input type="checkbox"/> 12+ college <input type="checkbox"/> 2/4 yr Grad | <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> N/A | <input type="checkbox"/> Farmer <input type="checkbox"/> Migrant Work <input type="checkbox"/> Seasonal Work <input type="checkbox"/> Other <input type="checkbox"/> None |
| Relationship to Applicant | | Work Status 18 or over | | Health Insurance | |
| <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other | | <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Unemployed 6 month + <input type="checkbox"/> Unemployed less than 6 mos. | | <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Minor under 18 | |
| | | | | <input type="checkbox"/> Direct purchase <input type="checkbox"/> Employment based <input type="checkbox"/> Military Health Care <input type="checkbox"/> Adults State Health Ins. | <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP <input type="checkbox"/> None |
| Other income received | | | Receive Non-Cash Benefits | | |
| <input type="checkbox"/> Child Support <input type="checkbox"/> SS Disability <input type="checkbox"/> SS Retirement <input type="checkbox"/> SSI <input type="checkbox"/> Pension <input type="checkbox"/> Private Disability <input type="checkbox"/> TANF | | | <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Alimony/Spousal Support <input type="checkbox"/> VA Service Connected Disability <input type="checkbox"/> VA Non-Service Connected Dis. <input type="checkbox"/> Unemployment Benefit <input type="checkbox"/> None | | |
| | | | <input type="checkbox"/> SNAP (Food stamps) <input type="checkbox"/> Childcare Voucher <input type="checkbox"/> Affordable Care Subsidy <input type="checkbox"/> Housing Choice Voucher | | |
| | | | <input type="checkbox"/> Public Housing <input type="checkbox"/> HUD-VASH <input type="checkbox"/> WIC <input type="checkbox"/> None | | |

| | | | | | |
|--|--|---|--|---|---|
| Household Member First Name: | | Last Name: | | Middle Initial: | |
| Date of birth: | | SS #: | | | |
| Gender | Race | Ethnicity | Education | Military Status | Seasonal Work |
| <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other | <input type="checkbox"/> African American /Black <input type="checkbox"/> American Indian <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Multi-Race | <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic | <input type="checkbox"/> 0-8 <input type="checkbox"/> 9-12 <input type="checkbox"/> HS Grad / GED <input type="checkbox"/> 12+ college <input type="checkbox"/> 2/4 yr Grad | <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> N/A | <input type="checkbox"/> Farmer <input type="checkbox"/> Migrant Work <input type="checkbox"/> Seasonal Work <input type="checkbox"/> Other <input type="checkbox"/> None |
| Relationship to Applicant | | Work Status 18 or over | | Health Insurance | |
| <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other | | <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Unemployed 6 month + <input type="checkbox"/> Unemployed less than 6 mos. | | <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Minor under 18 | |
| | | | | <input type="checkbox"/> Direct purchase <input type="checkbox"/> Employment based <input type="checkbox"/> Military Health Care <input type="checkbox"/> Adults State Health Ins. | <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP <input type="checkbox"/> None |
| Other income received | | | Receive Non-Cash Benefits | | |
| <input type="checkbox"/> Child Support <input type="checkbox"/> SS Disability <input type="checkbox"/> SS Retirement <input type="checkbox"/> SSI <input type="checkbox"/> Pension <input type="checkbox"/> Private Disability <input type="checkbox"/> TANF | | | <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Alimony/Spousal Support <input type="checkbox"/> VA Service Connected Disability <input type="checkbox"/> VA Non-Service Connected Dis. <input type="checkbox"/> Unemployment Benefit <input type="checkbox"/> None | | |
| | | | <input type="checkbox"/> SNAP (food stamps) <input type="checkbox"/> Childcare Voucher <input type="checkbox"/> Housing Choice Voucher <input type="checkbox"/> Affordable Care Subsidy <input type="checkbox"/> Public Housing | | |
| | | | <input type="checkbox"/> Public Housing <input type="checkbox"/> HUD-VASH <input type="checkbox"/> WIC <input type="checkbox"/> None | | |

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| | | | |
|--|---|-----------------------------------|---|
| Housing Information: | | | |
| Type | Private Home ___ | Mobile Home ___ | Apartment/Duplex ___ Other _____ # Bedrooms _____ |
| Subsidized/Public Housing? | Y / N | Own: ___Yes ___No | Monthly Mortgage \$ _____ |
| Rent ___Yes ___No | Monthly Rent \$ _____ | Utilities included in rent? Y / N | |
| Prior Weatherization Assistance? | Y / N | Date completed? | House built date: |
| Utility Information: | | | |
| Is the light bill/water bill under a different name? Who: _____ (You must bring a letter from this person, if this person is not a household member, stating that you are responsible for the bill) | | | |
| Electric Company: | _____ | Account # _____ | Heating ___ Cooling ___ Both ___ |
| Water Company: | _____ | Account # _____ | |
| Natural Gas Company: | _____ | Account # _____ | Heating ___ Cooling ___ Both ___ |
| Propane Company: | _____ | Account # _____ | Heating ___ Cooling ___ Both ___ |
| Type of A/C: | <input type="checkbox"/> Central / <input type="checkbox"/> Evaporative Cooler / <input type="checkbox"/> Window Unit / <input type="checkbox"/> None | | |
| Type of Heater: | <input type="checkbox"/> Central / <input type="checkbox"/> Space Heater / <input type="checkbox"/> Wall Furnace / <input type="checkbox"/> Fireplace Stove / <input type="checkbox"/> None | | |
| Is your A/C or Heater working properly? Yes No Are you in need of A/C or Heater Repair? Yes No | | | |
| Priority Information: | | | |
| 1. Have you ever received services from Community Council of South Central Texas, Inc. | | | Y / N |
| 2. Is anyone living in your household age 14-24 not going to school or working? Who? _____ | | | Y / N |
| Conflict of Interest Information: | | | |
| Is anyone in the household currently serve or related to a CCSCT employee, agency, consultant, officer or Board Member? If Yes, who and their position? _____ | | | Y / N |
| Case Management | | | |
| Are you willing and able to obtain a job, enroll in job training or engage in ways to increase your income by actively participating in CCSCT's Case Management Program? Are you willing to make a commitment to follow up on referrals, submit monthly income and to meeting with a Case Manager a minimum of once a month to successfully complete the Case Management program? | | | Y / N |
| Acknowledgement and Release of Information: | | | |
| I hereby give my permission to release any information and understand that it will be kept in the strict confidence. I understand that a photocopy or fax of this release is as valid as an original. I also give CCSCT, Community Services Program, permission to share with, to inquire about, make pledges and receive all Information from other agencies, utility vendors and employers as needed. I understand that I may be terminated for providing false information, threatening behavior, Sexual harassment, verbal abuse, theft or violation of CCSCT firearm policy. I understand if terminated, I will not be able to reapply for 1-2 years. | | | |
| Applicant to initial here: _____ | | | |
| FOR OFFICE USE ONLY: If there is a COI, this application requires the Executive Director's Approval and must be reviewed by the Program Director and a selection of peers. | | | |

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TEXAS DEPARTMENT OF HOUSING AND COMMUNITY AFFAIRS
Systematic Alien Verification for Entitlements (SAVE) System and US Citizenship/US National
Applicant Certification Form for WAP and CEAP

The program for which you are applying requires verification that you are a U.S. citizen, a non-citizen national, or a legal resident of the United States. Documentation of your status is required. This agency uses the Systematic Alien Verification for Entitlements (SAVE) System to verify the status of non-citizens.

| Household Member Name | US Citizen (Born or Naturalized) or U.S. National | | Qualified Alien | | OFFICE USE ONLY | |
|-----------------------|---|----|-----------------|----|-----------------------------|----------------|
| | | | | | Documentation Provided for: | |
| | | | | | Status | Identification |
| | Yes | No | Yes | No | | |
| | Yes | No | Yes | No | | |
| | Yes | No | Yes | No | | |
| | Yes | No | Yes | No | | |
| | Yes | No | Yes | No | | |
| | Yes | No | Yes | No | | |
| | Yes | No | Yes | No | | |
| | Yes | No | Yes | No | | |
| | Yes | No | Yes | No | | |
| | Yes | No | Yes | No | | |

To add additional household members, use another copy of this form

AM AWARE THAT I AM SUBJECT TO PROSECUTION FOR PROVIDING FALSE OR FRAUDULENT INFORMATION.

Applicant Signature

Date

Signature of agency staff certifying the above

Print Staff Name

Date



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**DECLARATION OF INCOME STATEMENT
(DECLARACION DE INGRESOS)**

| | | |
|---|--------------------------------|--------------------------|
| Applicant Name (Nombre del Solicitante) | Applicant Last Name (Apellido) | Suffix (Sufijo) |
| Address (Dirección) | City (Ciudad) | Zip Code (Código Postal) |

State the gross income for household members, **18 years and older**, who have **no documentation of the income** received in the **30 day period** prior to the date of application for assistance: *(Declarar el ingreso recibido por los miembros de su hogar, que tienen 18 años de edad ó mas, y que no tienen documentación de ingresos por los 30 días antes del aplicar para asistencia)*

| | |
|---------------|--|
| Name (Nombre) | Gross Income Received (Ingreso Bruto Recibido) |
| Name (Nombre) | Gross Income Received (Ingreso Bruto Recibido) |
| Name (Nombre) | Gross Income Received (Ingreso Bruto Recibido) |
| Name (Nombre) | Gross Income Received (Ingreso Bruto Recibido) |

My household has no documented proof of income due to the following situation *(Mi hogar no tiene prueba para documentar los ingresos por medio de tal razones):*

I certify that the above information is true and correct to the best of my knowledge and belief. *(Yo certifico que la información proveida de los ingresos es verdadera y correcta según mi saber y creencia.)*

I understand that the information will be verified to the extent possible; and that I may be subject to prosecution for providing false or fraudulent information. *(Comprendo que la información será verificada hasta donde sea posible y que puedo ser enjuiciado por haber proveido información falsa ó fraudulenta.)*

(Applicant Signature/Firma del Solicitante)

(Date/Fecha)

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Customer/Client Satisfaction Survey

Instructions: We need your feedback to help improve service and plan for the future.

Check the box to indicate which service(s) you received:

- Utility Assistance Weatherization WIC Education Services Employment Services
 Rental Assistance Case Management Referral Emergency Assistance Other _____

List the county where you receive services: _____

| | Strongly Disagree | Disagree | Neither Agree or Disagree | Agree | Strongly Agree |
|---|-----------------------|-----------------------|---------------------------|-----------------------|-----------------------|
| 1. When I entered the building, I was greeted and felt welcome. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. The facilities were clean. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. I was assisted in a timely manner. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. I was treated with respect. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. My needs were met. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. I was informed about other CCSCT programs or community services that could benefit me. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. I found the program service(s) helpful. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. I was satisfied with my overall experience and the services I received. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9. I am likely to use the program service(s) again. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10. I would recommend CCSCT to family/friends. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

I would be willing to participate in a discussion group to help CCSCT continue to improve. (Include name and phone number below)

Name: _____ Phone: _____

Comments/How can we better serve you? (If you were not satisfied, please tell us why).