



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

Please note: Due to changes in the Texas Administrative Code (TAC) and funding cuts, the amount of assistance you receive may be less than in previous years.

NOTICES:

1. If you have more than **5 people** in the home, please ask for an additional household member page.
2. Applications will not be put in processing order until ALL documents are received. **We cannot process incomplete applications!**
3. **You are still responsible for paying your bill** until your application is processed and you are notified of the outcome.
4. It can take up to 90 days or longer to process complete applications depending on the time of the year and the number of applications already in process. We will contact you once your application has been processed.
5. Applications are accepted by email, fax, mail, or drop off (unless otherwise noted) and will be processed according to priority and date received complete. (see # Notice #2 above)
6. This application is for screening purposes only and **does not guarantee your eligibility to receive services**. Payments are made within **45 days** from the voucher date **and are subject to availability of funds**.

REQUIRED DOCUMENTS: Completed application and...

- ❖ Social security cards for all household members
- ❖ Proof of ALL income **FOR THE PAST 30 DAYS** for every household member 18 years or older (Check stubs, Award letters from SS Administration only for Social Security/SSI/SSDI, etc. (including minor children) VA letter, unemployment, TANF letter, retirement, pension, child support, etc. All award letters must be dated for the **current year!**)
- ❖ If any household member **18 or over is NOT receiving any income, or has no proof of income**, (example is self-employed, works for cash, etc.) you must complete the attached **Declaration of Income Statement**.
- ❖ Citizenship papers: **no exceptions** (if you do not have these contact your local office for a list of acceptable documents)
 - Certified Birth Certificates for all household members born in USA (not hospital footprint form)
 - Proof of Legal Residency for all household members not born in USA (permanent resident card, visa, foreign passport, etc.)
- ❖ Identification: **no exceptions** (if you do not have these contact your local office for a list of alternative documents)
 - Photo DL/ID for anyone 16 or over
- ❖ A 12-month billing history from each of your energy providers, even if you are not receiving assistance from all of them. (ELECTRIC, NATURAL GAS AND/OR PROPANE) NOTE: If you have less than 12 months in your home, please provide the history for as many months as possible.
- ❖ Your current and past due electric and gas bills and disconnection notice, if applicable.

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, Assistant CS Program Director at phone number 830-625-6268 or email blacey@ccsct.org. Your complaint will be investigated within 10 days and complainant notified of results. If the complaint is regarding a denial due to income, the client will be reminded of the appeals process as outlined in the denial form.

**Check us out
on Social Media**





Community Council of South Central Texas
2026 Community Services Application

HEAD OF HOUSEHOLD INFORMATION		
First Name:	Last Name:	Middle Initial:
Date of birth:	SS #:	Contact Phone #
Residential Address:	Apt #:	
City, Zip	County:	
Mailing Address (if different):	Apt #:	
City, Zip	County:	
Email Address: please print		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	If female, are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relation to Applicant: <input type="checkbox"/> Applicant <input type="checkbox"/> Child <input type="checkbox"/> Friend <input type="checkbox"/> Foster Child <input type="checkbox"/> Grandparent <input type="checkbox"/> Guardian <input type="checkbox"/> Parent <input type="checkbox"/> Partner <input type="checkbox"/> Sibling <input type="checkbox"/> Spouse <input type="checkbox"/> Stepparent <input type="checkbox"/> Other Relative		
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	Race: <input type="checkbox"/> Black/African American <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Multi-Race <input type="checkbox"/> Other	
Education: <input type="checkbox"/> 0-8 <input type="checkbox"/> 9-12 <input type="checkbox"/> GED <input type="checkbox"/> HS Grad <input type="checkbox"/> 12+ college <input type="checkbox"/> 2/ yr. Grad <input type="checkbox"/> 4 + yr Grad <input type="checkbox"/> Vocational School		
Health Insurance: <input type="checkbox"/> Direct purchase <input type="checkbox"/> Employment based <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Military Health Care <input type="checkbox"/> None <input type="checkbox"/> CHIP <input type="checkbox"/> Adults State Health Ins.		
Military Status: <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> N/A <input type="checkbox"/> Surviving Spouse, or <input type="checkbox"/> Dependent	Are You Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No Are you receiving disability: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Work Status: <input type="checkbox"/> Disabled <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Migrant/Seasonal Farmworker <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed 6 months or longer <input type="checkbox"/> Unemployed less than 6 mos. <input type="checkbox"/> Minor under 18		
Other Income Sources: <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> SS Disability <input type="checkbox"/> SS Retirement <input type="checkbox"/> SSI <input type="checkbox"/> Survivor SS <input type="checkbox"/> Private Pension/Retirement <input type="checkbox"/> Private Disability <input type="checkbox"/> TANF <input type="checkbox"/> Worker's Comp <input type="checkbox"/> VA Service Connected Disability <input type="checkbox"/> VA Service Non-Connected Disability <input type="checkbox"/> Unemployment Benefit <input type="checkbox"/> None		
Disconnected Youth: Are you age 14-24 not working or attending school <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is anyone in the household receiving the following Non-Cash Benefits? (check all that apply) <input type="checkbox"/> Affordable Care Subsidy <input type="checkbox"/> Childcare Voucher <input type="checkbox"/> Housing Choice Voucher <input type="checkbox"/> HUD-VASH <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Public Housing <input type="checkbox"/> SNAP (Food stamps) <input type="checkbox"/> TBRA <input type="checkbox"/> WIC <input type="checkbox"/> None		

“Important information for former military services members. Anyone who served in any branch of the United States Armed Forces including Army, Navy, Marines, Coast Guard, Reserves or National Guard, may be eligible for additional benefits and services. For more information, visit the Texas Veterans Portal at <https://veterans.portal.texas.gov> .“

CCSCT -2026 Community Services Application

Please complete the following for all other household members. Please answer **ALL** questions.

Other Household Member-2		
First Name:	Last Name:	Middle Initial:
Date of birth:	SS #:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	If female, are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relation to Applicant: <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Child <input type="checkbox"/> Friend <input type="checkbox"/> Foster Child/Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Parent <input type="checkbox"/> Partner <input type="checkbox"/> Spouse <input type="checkbox"/> Stepparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Other Non-relative		
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	Race: <input type="checkbox"/> Black/African American <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Multi-Race <input type="checkbox"/> Other	
Education: <input type="checkbox"/> 0-8 <input type="checkbox"/> 9-12 <input type="checkbox"/> GED <input type="checkbox"/> HS Grad <input type="checkbox"/> 12+ college <input type="checkbox"/> 2/ yr. Grad <input type="checkbox"/> 4 + yr Grad <input type="checkbox"/> Vocational School		
Health Insurance: <input type="checkbox"/> Direct purchase <input type="checkbox"/> Employment based <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Military Health Care <input type="checkbox"/> None <input type="checkbox"/> CHIP <input type="checkbox"/> Adults State Health Ins.		
Military Status: <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> N/A <input type="checkbox"/> Surviving Spouse, or <input type="checkbox"/> Dependent	Are they disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No Are they receiving disability: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Work Status: <input type="checkbox"/> Disabled <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Migrant/Seasonal Farmworker <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed 6 months or longer <input type="checkbox"/> Unemployed less than 6 mos. <input type="checkbox"/> Minor under 18		
Other Income Sources: <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> SS Disability <input type="checkbox"/> SS Retirement <input type="checkbox"/> SSI <input type="checkbox"/> Survivor SS <input type="checkbox"/> Private Pension/Retirement <input type="checkbox"/> Private Disability <input type="checkbox"/> TANF <input type="checkbox"/> Worker's Comp <input type="checkbox"/> VA Service Connected Disability <input type="checkbox"/> VA Service Non-Connected Disability <input type="checkbox"/> Unemployment Benefit <input type="checkbox"/> None		
Disconnected Youth: Are they age 14-24 not working or attending school <input type="checkbox"/> Yes <input type="checkbox"/> No		

Other Household Member-3		
First Name:	Last Name:	Middle Initial:
Date of birth:	SS #:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	If female, are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relation to Applicant: <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Child <input type="checkbox"/> Friend <input type="checkbox"/> Foster Child/Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Parent <input type="checkbox"/> Partner <input type="checkbox"/> Spouse <input type="checkbox"/> Stepparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Other Non-relative		
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	Race: <input type="checkbox"/> Black/African American <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Multi-Race <input type="checkbox"/> Other	
Education: <input type="checkbox"/> 0-8 <input type="checkbox"/> 9-12 <input type="checkbox"/> GED <input type="checkbox"/> HS Grad <input type="checkbox"/> 12+ college <input type="checkbox"/> 2/ yr. Grad <input type="checkbox"/> 4 + yr Grad <input type="checkbox"/> Vocational School		
Health Insurance: <input type="checkbox"/> Direct purchase <input type="checkbox"/> Employment based <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Military Health Care <input type="checkbox"/> None <input type="checkbox"/> CHIP <input type="checkbox"/> Adults State Health Ins.		
Military Status: <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> N/A <input type="checkbox"/> Surviving Spouse, or <input type="checkbox"/> Dependent	Are they disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No Are they receiving disability: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Work Status: <input type="checkbox"/> Disabled <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Migrant/Seasonal Farmworker <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed 6 months or longer <input type="checkbox"/> Unemployed less than 6 mos. <input type="checkbox"/> Minor under 18		
Other Income Sources: <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> SS Disability <input type="checkbox"/> SS Retirement <input type="checkbox"/> SSI <input type="checkbox"/> Survivor SS <input type="checkbox"/> Private Pension/Retirement <input type="checkbox"/> Private Disability <input type="checkbox"/> TANF <input type="checkbox"/> Worker's Comp <input type="checkbox"/> VA Service Connected Disability <input type="checkbox"/> VA Service Non-Connected Disability <input type="checkbox"/> Unemployment Benefit <input type="checkbox"/> None		
Disconnected Youth: Are they age 14-24 not working or attending school <input type="checkbox"/> Yes <input type="checkbox"/> No		

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Other Household Member-4		Please ask for additional pages if needed	
First Name:		Last Name:	Middle Initial:
Date of birth:		SS #:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	If female, are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Relation to Applicant: <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Child <input type="checkbox"/> Friend <input type="checkbox"/> Foster Child/Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Parent <input type="checkbox"/> Partner <input type="checkbox"/> Spouse <input type="checkbox"/> Stepparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Other Non-relative			
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic		Race: <input type="checkbox"/> Black/African American <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Multi-Race <input type="checkbox"/> Other	
Education: <input type="checkbox"/> 0-8 <input type="checkbox"/> 9-12 <input type="checkbox"/> GED <input type="checkbox"/> HS Grad <input type="checkbox"/> 12+ college <input type="checkbox"/> 2/ yr. Grad <input type="checkbox"/> 4 + yr Grad <input type="checkbox"/> Vocational School			
Health Insurance: <input type="checkbox"/> Direct purchase <input type="checkbox"/> Employment based <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Military Health Care <input type="checkbox"/> None <input type="checkbox"/> CHIP <input type="checkbox"/> Adults State Health Ins.			
Military Status: <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> N/A <input type="checkbox"/> Surviving Spouse, or <input type="checkbox"/> Dependent		Are they disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No Are they receiving disability: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Work Status: <input type="checkbox"/> Disabled <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Migrant/Seasonal Farmworker <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed 6 months or longer <input type="checkbox"/> Unemployed less than 6 mos. <input type="checkbox"/> Minor under 18			
Other Income Sources: <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> SS Disability <input type="checkbox"/> SS Retirement <input type="checkbox"/> SSI <input type="checkbox"/> Survivor SS <input type="checkbox"/> Private Pension/Retirement <input type="checkbox"/> Private Disability <input type="checkbox"/> TANF <input type="checkbox"/> Worker's Comp <input type="checkbox"/> VA Service Connected Disability <input type="checkbox"/> VA Service Non-Connected Disability <input type="checkbox"/> Unemployment Benefit <input type="checkbox"/> None			
Disconnected Youth: Are they age 14-24 not working or attending school <input type="checkbox"/> Yes <input type="checkbox"/> No			

Other Household Member-5			
First Name:		Last Name:	Middle Initial:
Date of birth:		SS #:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	If female, are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Relation to Applicant: <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Child <input type="checkbox"/> Friend <input type="checkbox"/> Foster Child/Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Parent <input type="checkbox"/> Partner <input type="checkbox"/> Spouse <input type="checkbox"/> Stepparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Other Non-relative			
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic		Race: <input type="checkbox"/> Black/African American <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Multi-Race <input type="checkbox"/> Other	
Education: <input type="checkbox"/> 0-8 <input type="checkbox"/> 9-12 <input type="checkbox"/> GED <input type="checkbox"/> HS Grad <input type="checkbox"/> 12+ college <input type="checkbox"/> 2/ yr. Grad <input type="checkbox"/> 4 + yr Grad <input type="checkbox"/> Vocational School			
Health Insurance: <input type="checkbox"/> Direct purchase <input type="checkbox"/> Employment based <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Military Health Care <input type="checkbox"/> None <input type="checkbox"/> CHIP <input type="checkbox"/> Adults State Health Ins.			
Military Status: <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> N/A <input type="checkbox"/> Surviving Spouse, or <input type="checkbox"/> Dependent		Are they disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No Are they receiving disability: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Work Status: <input type="checkbox"/> Disabled <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Migrant/Seasonal Farmworker <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed 6 months or longer <input type="checkbox"/> Unemployed less than 6 mos. <input type="checkbox"/> Minor under 18			
Other Income Sources: <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> SS Disability <input type="checkbox"/> SS Retirement <input type="checkbox"/> SSI <input type="checkbox"/> Survivor SS <input type="checkbox"/> Private Pension/Retirement <input type="checkbox"/> Private Disability <input type="checkbox"/> TANF <input type="checkbox"/> Worker's Comp <input type="checkbox"/> VA Service Connected Disability <input type="checkbox"/> VA Service Non-Connected Disability <input type="checkbox"/> Unemployment Benefit <input type="checkbox"/> None			
Disconnected Youth: Are t age 14-24 not working or attending school <input type="checkbox"/> Yes <input type="checkbox"/> No			

Please answer ALL questions

Housing Information:

Do you Rent? or Own?

Type: Private Home (house) Mobile Home/RV Apartment/Duplex Other _____

Utility Information:

Are your utility bills in 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 Name: _____ Acct.# _____ Heating Cooling Both

Gas/ Propane Company: _____ Acct.# _____ if Propane % _____ remaining

Type of A/C: Central / Evaporative Cooler / Window Unit / None

Type of Heater: Central / Space Heater / Wall Furnace / Fireplace / Stove / None

Is your A/C or Heater working properly? **Yes** **No** / Are you in need of A/C or Heater Repair? **Yes** **No**

Weatherization Information:

Has your home ever received Weatherization? **Yes** **No** If yes, date: _____ House build date _____

Would you like a referral to a Weatherization program? **Yes** **No**

(if eligible may repair or replace low energy efficient gas space heaters, air conditioners, install attic and/or wall insulation, repair doors, repair windows, replace broken glass and caulk around loose panes in windows, weather strip around doors and attic hatches, patch holes in the walls where air is coming in or out of the house, patch holes in floors and ceilings, caulk around window and door frames, wrap exposed water pipes)

Early Head Start / Head Start:

If you have a child/children birth to 5 years old, would you like a referral to a Head Start Program? **Yes** **No**
(if available)

Early Head Start - birth – 3 yrs (Supports infants and toddlers, and their families, with comprehensive child development and family support services.) or Head Start - age 3- 5 (prepares children for school readiness through early learning, health, and family well-being services)

Veteran Services:

If you are a veteran, surviving spouse, or dependent, would you like a referral for veteran services? (if eligible, may assist with utilities, rent, mortgage, deposits, etc.) **Yes** **No**

Please answer ALL questions

Conflict of Interest Information:

Is anyone in the household currently serving, or related to a CCSCT employee, agency consultant, officer, or board member? If yes, enter name of person affiliated with or staff of CCSCT and position. **Name:** _____ **Posicionn:** _____ Yes No

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? Will you 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? Yes No

CCSCT Termination Policy

I understand that I may be terminated for **providing false information, exhibiting ANY type of threatening behavior, sexual harassment, verbal abuse (including cursing), theft, or violation of the CCSCT firearm policy.** I understand if terminated, **I may not be able to reapply for services for 1-2 years.** Yes No

Release of information to an authorized person outside my household: In addition to the release of information below, I authorize CCSCT to provide information regarding my application status and assistance to the individual not residing in my household named below. This authorization is valid for one year unless it is revoked in writing by me, the applicant.

Printed First/Last Name of Authorized Person

Relationship

Phone Number

Email Address

CCSCT Acknowledgement and Release of Information:

I hereby give my permission to release my household’s information for program purposes only and understand that it will otherwise be kept in strict confidence. I understand that a photocopy or fax of this release is as valid as the original. Further, I also give CCSCT permission to share with, to inquire about, make pledges and receive my household’s information from other agencies, utility vendors and employers as needed. **In addition, CCSCT may disclose information to anyone 18 years or older** who resided in my household at the time of this application was signed and dated by the applicant

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 a Federal Offense punishable by fine or imprisonment.

Applicant signature _____

Date _____

Staff Signature _____

Date _____

**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.

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

Household Member Name	US Citizen (Born or Naturalized) or U.S. National	Qualified Alien	OFFICE USE ONLY	
			Citizenship Documents	Identification Documents
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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

Applicant Signature

Date

Signature of agency staff certifying the above documents

Printed Staff Name

Date

**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 income, or 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 proveída 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 proveído información falsa ó fraudulenta.)*

(Applicant Signature/Firma del Solicitante)

(Date/Fecha)

Customer/Client Satisfaction Survey

Instructions

We need your feedback to help improve service and plan for the future. **Check the boxes to indicate which services 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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The facilities were clean.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I was assisted in a timely manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I was treated with respect.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. My needs were met.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I was informed about other CCSCT programs or community services that could benefit me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I found the program service(s) helpful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I was satisfied with my overall experience and the services I received.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I am likely to use the program service(s) again.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I would recommend CCSCT to family/friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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).