# SAN BENITO COUNTY

TRACEY BELTON
DIRECTOR

Health & Human Services Agency

COMMUNITY SERVICES & WORKFORCE DEVELOPMENT

*1161 SAN FELIPE ROAD, BLDG B• • HOLLISTER, CA 95023*

*(831) 637-9293 • FAX (831) 634-0785*


**Client Name/**
*Nombre del Solicitante:* _____ Date/*Fecha*: _____

Intake Worker: _____ Last 4 digits of SSN
*# ultimos 4 Número De Seguro Social* _____


***Programa de Realiza tus SUEÑOS***

| | | |
|---|---|---|
| ☐ | Income Verification for the past 30 days from all members of your household. | *Verificación de ingresos de los últimos 60-días de todos los miembros de su casa.* |
| ☐ | Photo I.D. for all the adults (18+) in the household. | *Identificación con foto de todos los adultos (18+) en su hogar.* |
| ☐ | Social Security cards for all children and adults. | *Tarjetas de Seguro Social de todos los adultos y niños* |
| ☐ | Birth Certificates for all children | *Certificado de nacimiento de todo los niños y adultos en la casa* |
| ☐ | Provide proof that you are a San Benito County resident last 60 days | *Prueba de ser residente del Condado de San Benito.* |
| ☐ | Youth Questionnaire | *Cuestionario juventud* |
| ☐ | Activity flyer or brochure from business, organization, club | *Folleto de actividad de parte de la empresa, organización, club* |

CSBG 2020 200% of Federal Poverty Level –Effective To September 30, 2021 [2021 Rates Available July, 2021}

| Number in Household | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| Annual Income | $25,760 | $34,840 | $43,920 | $53,000 | $62,080 | $71,160 | $80,240 | $89,320 |

*CSBG 2020 100% of Federal Poverty Level—Effective October 1, 2021 [2021 Rates Available July, 2021

| Number in Household | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| Annual Income | $12,880 | $17,420 | $21,960 | $26,550 | $31,040 | $35,580 | $40,120 | $44,660 |

_____

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

☐ Approved ☐ Denied

_____
Staff Signature

Reviewed By: _____



The County of San Benito complies with the Americans with Disabilities Act (ADA) by assuring that auxiliary aids for services are available upon request to persons with disabilities. Persons with hearing disabilities can call the TDD/TTY phone (831) 637-3265. Persons requiring any special needs for access to should call the CSWD office at 831-637-9293 at least five business days before the needed date to arrange for the special accommodations.

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## DREAM CATCHER CARES ACT
## COVID-19 STATEMENT OF NEED

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

☐ Acquired COVID-19 ☐ Loss of Employment due to COVID-19

☐ Unable to work due to care of family member ☐ Reduction of work hours 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

---

**OFFICE USE ONLY**

The above applicant statement is being utilized for documentation of the following eligibility criteria:

_____

_____

_____

_____ _____

Signature of CSWD Staff Date

Rev. 04.30.2021

| REASON (S) FOR ASSISTANCE | *RAZON(ES) PARA LA ASISTENCIA* |
|---|---|
| Please state the reason(s) why you are requesting assistance from the Dream Catcher Program.<br><br>If you need more space, please use the back of sheet | *Por favor indiqué la razón(es) del porque usted necesita asistencia del Programa de Asistencia-* ***REALIZA TUS SUEÑOS***<br><br>*Si necesita mas espacio, favor de usar el reverso de esta pagina.* |

***To be completed by Youth Participant /Completado por el participant juvenil***

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|---|---|
| I hereby certify, under penalty of perjury that the above information is correct to the best of my knowledge | *Yo, certifico dentro pena de perjurio que la información escrita arriba es la verdad en lo mejor de mi conocimiento* |

Client Signature/*Firma del Solicitante*

Date/*Fecha*

| DREAM CATCHER PROGRAM | PROGRAMA DE ***REALIZA TUS SUEÑOS*** |
|---|---|
| **TO BE COMPLETED BY PARTICIPANT/CHILD** | ***DEBE SER COMPLETADO POR EL PARTICIPANTE/NINO(A)*** |
| Please answer the questions below and add anything we should know about you? | *Por favor, conteste las siguientes preguntas y añadir algo que debamos saber sobre usted?* |

| |
|---|
| **What do you do when you come home after school each day?**<br>*¿Qué se hace cuando llega a casa después de la escuela todos los días?* |
| |
| **What is your favorite outdoor activity?**<br>*¿Cuál es su actividad favorita en tu tiempo libre?* |
| |
| **If you could participate in an after school program (sports, arts, music, etc., what would it be?**<br>*¿Si pudieras participar en un programa después de la escuela (como deportes, arte, música, etc.), ¿qué sería?* |
| |
| **How will this program benefit you?**<br>*¿Cómo será este programa un beneficio para ti?* |
| |

Child Signature/*Firma del Nino(a)* Date/*Fecha*

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

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# 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:_____

City_____ State_____ Zip Code_____

Phone:_____Message Phone:_____

Email: _____

Birthdate:_____ Driver's License: _____

Other Names Used:_____

Gender: ☐ Female ☐ Male

## 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:

☐ English
☐ Spanish
☐ ASL (American Sign Language)
☐ Other: _____

Citizen:

- ☐ Citizen
- ☐ Legal Alien-Eligible
- ☐ Legal Alien-Ineligible
- ☐ Undocumented

Disability Status: ☐ YES ☐ NO ☐ Unspecified

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

Race: Select One:

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

## Income (Last 30 Days) **Verification Required

Annual Income Report all current income (wages, child support, SSI, Unemployment, pension) 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.

What is your/your family current source of income?

| Family Member | Income Source | Monthly Income | Total Income Last 30 Days** |
|---|---|---|---|
| | | | |
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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.**

| | |
|---|---|
| **Applicant Signature** | **Date** |
| CSWD Staff Signature | Date |

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## APPLICANT STATEMENT

**I, _____, HEREBY CERTIFY, UNDER PENALTY OF PERJURY, THAT:**
Name/*Nombre*

*If applicant cannot obtain a satisfactory witness or provide a telephone contact, explain above.*

**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 programs and/or penalties as specified by law.**

Applicant's signature/*Firma* Date/*Fecha*

Address/*Domicilio*

City State Zip

### OFFICE USE ONLY

The above applicant statement is being utilized for documentation of the following eligibility criteria:

Signature of CSWD Staff Date

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PLEASE READ CAREFULLY AND FILL IN ALL GREY AREAS OF THIS FORM ONLY / 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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## RELEASE OF INFORMATION AUTHORIZATION

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.

## AUTORIZACIÓN PARA OBTENER INFORMACIÓN

Usted ha solicitado asistencia de la oficina de Servicios de Comunidad y Desarrollo de Trabajadores Unidos (CSWD). El uso de estos fondos está limitado a esas personas que son elegibles. Es la póliza de la Agencia de verificar la información que es pertinente a su caso para determinar si Usted es elegible para la asistencia. La determinación de que si es elegible o no se hace cuando todos los documentos han sido recibidos por la oficina de Servicios de Comunidad y Desarrollo de Trabajadores Unidos.

Cuando usted firme este "Autorización" está dando permiso a la oficina de Servicios de Comunidad y Desarrollo de Trabajadores Unidos (CSWD) a verificar la información que ha sido sometido que incluye; ingresos y beneficios recibidos, fecha de nacimiento, ciudadanía, prueba de ser residente del condado de San Benito, número de seguro social, trabajo, educación, existencia de parientes, estado legal (condenas anteriores, encarcelamientos, libertad condicional) y otra información requerida para verificar si usted es elegible, para completar su solicitud y, para evitar la duplicación de servicios.

Por este medio doy permiso y autorizo que la oficina de Servicios de Comunidad y Desarrollo de Trabajadores Unidos (CSWD) reciba o de información relacionada con mi solicitud a otras agencias de servicios.

Además, está usted confirmando que la información que nos ha dado es verdad y correcta según su conocimiento, y que usted entiende que al falsifica a propósito la información en esta solicitud, para determinar si usted es elegible, pueda estar cometiendo un crimen de la cual usted pueda ser castigado (a) y puede ser descalificado (a) del programa y puede resultar en una acción para recubrir dinero pagado durante su solicitud.

PRINT NAME/*NOMBRE EN MOLDE*

SOCIAL SECURITY NUMBER/*NÚMERO DE SEGURO SOCIAL*

APPLICANT SIGNATURE/*FIRMA DEL CLIENTE*

DATE/FECHA

Rev 09.2020

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**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? |
|---|
| |
| |
| |

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

**C. FAIR HEARING/APPEALS PROCESS SUMMARY FORM:**

a. I hereby acknowledge receipt of a Fair Hearing/Appeals Process Summary Form

**DECLARACION DE NEPOTISMO**

1. ¿Es un miembro de su familia inmediata (cónyuge, padre, hijo, hermano, hermana, tío, tía, sobrina, sobrino, suegro, padrastro o hijastro) un funcionario electo de la ciudad o del condado, o miembro de la mesa directiva de la Agencia de Servicios y Trabajadores Unidos de Desarrollo? En caso afirmativo, ¿cuál es su nombre, título elegido y relación con usted? ☐ Si ☐ No

| ¿Si es que sí, cuál es su nombre, título y parentesco? |
|---|
| |
| |
| |

2. ¿Es miembro de su familia inmediata (cónyuge, padre, hijo, hermano, hermana, tío, tía, sobrina, sobrino, suegros, padrastros o hijastros) un empleado de la ciudad, el condado o un subcontratista de la ciudad, el condado o el departamento de Agencia de Servicios y Trabajos Unidos de Desarrollo? En caso afirmativo, ¿cuál es su nombre, posición y relación con usted? ☐ Si ☐ No

| ¿Si es que sí, cuál es su nombre, título y parentesco? |
|---|
| |
| |
| |

☐ **Según mi conocimiento, no tengo familiares de ningún grado, que trabajen para el condado de San Benito.**

**C. RESUMEN DEL PROCESO DE AUDIENCIA JUSTA / APELACIÓNES**

a. Recibí el formulario para el proceso para pedir una audiencia imparcial e/o apelación.

Initials/*Iniciales*

Signature/*Firma del cliente*

Date/*Fecha*

Social Security Number/*Número de Seguro Social*

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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*