City of Plymouth

COVID-19 Subsistence Payment Program Application

CUSTOMERINFORMATION (Entire application must be completed and signed. Please print clearly.)

Account Number:		
Name *(as shown on your bill)*	SSN#	DOB
Service Address		
City	State	Zip Code
Telephone Number	Email Address *(optional)*	

I certify that the information given on this form is 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 or State funds, which may include immediate repayment of all Federal or State funds received and/or prosecution under the law. I understand that the information on this form is subject to verification by state or federal personnel as part of compliance monitoring.

Signature_____ Date_____

Public Service Program SELF-CERTIFICATION of Income *for*

☐ City of / ☐Town of / ☐ County of_____CDBG Funded Activity

Name of Public Service: CV-19 Subsistence Payments

HUD Code: _____

Page 1 to be filled out by Participant

Part I: Confidential Participant / Beneficiary HUD Demographic Information

(This section is voluntary.)

Ethnicity (Select One)	☐ **Not Hispanic**	☐ **Hispanic**
Race (Select One)		
☐ White	☐ Am. Indian/Alaskan Nat. & White	
☐ Black/African American	☐ Asian & White	
☐ Asian	☐ Black/African American & White	
☐ American Indian/Alaskan Native	☐ Am. Indian/Alaskan & Black/African	
☐ Nat. Hawaiian/Other Pacific Isl.	☐ Other Multi-Racial	
Other Demographic Data (Select all that Applies)		
☐ Female Head of Household ☐ Participant Disable ☐ Veteran ☐ Elderly	☐ Single / Non Elderly ☐ Related/Single Parent ☐ Related/Two Parent ☐ Other (_____)	

Part II: Confidential Participant / Beneficiary Income Certification

(Must be completed and signed prior to providing public service.)

My total family size consists of_____members, and the total gross annual income* for all adult members is $_____.

*Gross annual income must include all sources of income (wages, child support, SSI, unemployment, pension, income from assets, etc., but does not include the income of live-in aids, per 24 CFR 5.403).

I certify that the information given on this form is 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 or State funds, which may include immediate repayment of all Federal or State funds received and/or prosecution under the law. I understand that the information on this form is subject to verification by state or federal personnel as part of compliance monitoring.

Participant / Beneficiary Information:

Signature:_____ **Date:**_____

Name (print): _____

Physical Home Address:_____,**(City)**_____

Public Service Program SELF-CERTIFICATION Verification by
☐ City of / ☐Town of / ☐ County of_____for CDBG Funded

Page 2 to be filled out by Program Operator

Public Service Information:

Name Public Service(s): _____

Name of Agency Providing the Public Service: _____

Address where Public Service is being provided:_____, City_____

Public Service Funded By: ☐ Grant #:_____ - Or - ☐ PI Waiver in Fiscal Year:_____

Program Service Area: ☐ Citywide - Or - ☐ County wide - Or - Other (describe): _____

Participant / Beneficiary Family Income and Location Verification:

Effective Date of the Income Limit Chart being used: _____

Family is: ☐ Extremely Income ☐ Very Low Income ☐ Low Income

☐ Does Not Qualify

Program Operator must:

1) Print the current HCD Income limits from the HCD website (NOT HUD's), and
2) Circle the applicable family size and annual income on HCD limit printout, and
3) Include the copy of the circled printout in the program's applicant file; and
4) Must complete confidential demographic data, if participant/beneficiary leaves blank.

Name of Participant / Beneficiary: _____

Physical home address is: ☐ Within Service Area ☐ Outside of Service Area

Note: Significant number of program participants/ beneficiaries must reside in the program service area.

Program Operator Certification: *I certify that the Participant / Beneficiary demographic data and public service information is true and correct, to the best of my knowledge. I certify that, using the current HCD annual income publication compared to the stated family size and income, the income level shown above is true and correct. I certify that Participant / Beneficiary residency status is true and correct, per the requirements of 24 CFR 570.486(b) and/or (c) as applicable.*

Note: This completed certification, whether Beneficiary was assisted or not, must be maintained in the Program file for review at time of monitoring.

_____ _____

Printed Program Operator Name (printed) **Job Title**

Signature:_____ **Date**:_____

Eligibility is valid until (three years after signed certification) Date: _____