YVEDDI CARES ACT PROGRAM APPLICATION

Last Name		First Name:		Initial	
Address:					
City/State/Zip					
County					
Is this address	☐ Temporary (friend, relative, shelter) ☐ Permanent (Own, Rent)				
Telephone:		Cell:			
E-mail					
Total number in household:					

Please check any of the following services needed due to COVID-19:

☐ Educational Training	☐ Emergency Assistance
☐ Employment	☐ Food
☐ Financial Assistance	☐ Housing
☐ Transportation	☐ Rental Assistance
☐ Child Care	

What caused the need for assistance:

☐ Unemployed due to COVID-19	☐ Laid-off due to COVID-19
☐ Work hours has been reduced due to COVID-19	☐ Furloughed due to COVID-19
	☐ Other: _____

Income:

Please LIST all income and the source. This includes employment, unemployment, child support, Work First, Social Security, etc.

Household Member	Income Source Or Employer Name	Monthly Amount
		$
		$
		$
		$

Check which resources you currently receive (if any):

☐ Employment Income	☐ Self-Employment	☐ Unemployment
☐ Social Security	☐ Section 8 Housing Voucher	☐ Utility Allowance
☐ Work First Benefits	☐ Retirement/Pension	☐ Child Support
☐ Food Stamps	☐ Medicaid/Medicare	☐ Financial Aid

CERTIFICATION AND WAIVER OF PRIVACY RIGHTS

"The Privacy Act of 1974 establishes certain regulatory guidelines for the collection and dissemination of information contained as a record on individuals participating in public/private service programs. In order to fully comply with the Act, our agency is required by law to have your consent to obtain information, and to release information, that will enable us to better serve your needs."

This consent is valid for 60 days from date of signature. However, you may revoke this consent at any time.

I, _____, do hereby give my permission to YVEDDI CARES ACT Program to obtain, verify, and utilize this information to process my application for services.

I certify that all information provided herein is true to the best of my knowledge. I am aware that this information is subject to review and verification and that I may have to provide documentation to support it.

I am aware that I may be denied assistance if I am found ineligible or if I do not meet the program requirements. I understand I have the right to appeal any denial of service or assistance for which I may be eligible. I am aware that I may be prosecuted if I have knowingly given false information in order to receive assistance.

I hereby grant permission and authorize any employer and any public or private institution to share information regarding my past and/or present financial situation in order to determine whether or not I am eligible for services. I allow release of information contained herein for purposes of verification.

Right to Appeal

If you have been denied services and/or discharged from the CARES ACT Program offered through Yadkin Valley Economic Development District, Inc. (YVEDDI), you have the right to request an appeal. A written request must be submitted to the Community Service Director within 10 working days of the denial/discharge notice. A verbal request may be substituted in instances of proven lack of access to resources enabling you to submit the request in writing. Within 7 days of receipt of the request for an appeal from the person denied services, a hearing will be held at which time the applicant shall be given an opportunity to present evidence as to why the denial/discharge should be overruled. Within 7 days of the hearing, the person will receive notification of the grant recipient's decision as to whether or not the applicant is eligible for services and/or reinstatement into the program.

_____ _____

Applicant's Signature Date

_____ _____

Staff Signature Date

Print and mail completed application to:
CSBG CARES ACT Program
P. O. Box 309 ▪ Boonville, NC 27011 or
save application to your computer, fill out and email to: yveddicares.com