



COMMUNITY SERVICES OFFICE

of Hot Springs and Garland County, Arkansas

P.O. Box 1175, Hot Springs, Arkansas 71902

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CSBG CLIENT APPLICATION

COVID RELIEF PROGRAM CHECKLIST

***BELOW IS A LIST OF THE ITEMS NEEDED TO APPLY FOR COVID RELIEF ASSISTANCE:**

- Completely fill out application and make sure you sign all pages on which a signature is required.
- Current Rental Lease Agreement signed by you and the landlord.
- Proof of income for all household members 18 and older from the previous or current month.
- Proof of Social Security, SSI, Retirement, Pension(s), Worker's Comp. Allowance, Unemployment (If receiving/or not receiving Unemployment Benefits, please provide a printout of your weekly benefit amount) from the previous month.
- Copy of picture ID or Driver's License.

COMMUNITY SERVICES OFFICE – CASE MANAGEMENT ORIENTATION FORM

Date: ____/____/____

Classroom/Location: _____

Household Information: Number of Persons Living in the Household _____ Race _____

Names of all Occupants:		Age	Names continued:		Age
1			6		
2			7		
3			8		
4			9		
5			10		

Name of Head of Family: _____ Student's First Name: _____

Address: _____

Home Phone: _____ Contact #: _____

Mom's Cell: _____ Dad's Cell: _____

Living Situation:
(Check all that Apply)

Education/Work Situation:
(Check all that Apply) Mom Dad

Single Parent Home	
Two Parent Home	
Single	
Married	
Living Together	
Living with Parents	
Living with Other:	
Other:	

Bachelor's or Above		
Associate's Degree		
Vocational Degree		
Some College		
High School Diploma		
GED		
Less than High School		
Employed		
In School		

Use of Pictures: Yes _____ No _____

Short-Term Goal: _____

Long-Term Goal: _____

Assistance Needed:

Assistance Receiving:

Childcare		Housing	
Clothing		Medical	
College		Mental Health	
Employment		Transportation	
ESL Training		Utilities	
Food		Other:	
GED		Other:	

Child Support	
HUD	
SNAP	
SSI	
TEA	
WIC	
Other	

Specific Purpose of Visit: _____

COMMUNITY SERVICES OFFICE – INTAKE INFORMATION

Date: ____/____/____

First Name: _____ Last Name: _____

Date of Birth: ____/____/____ Social Security Number: ____/____/____

Gender: (Circle One) Male / Female School District: _____

Street Address: _____

Mailing Address (If Different) _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Cell Phone Provider: _____

EDUCATION LEVEL: (Circle One) 0-8 / 9-12 Non-Graduate / High School Graduate / GED /
Some Post-Secondary School / 2-4 Years of College / Unspecified

RACE: (Circle One) American Indian-Alaskan Native / Asian / Biracial-Multiracial /
Black-African American / Native Hawaiian-Pacific Islander / White / Other / Unspecified

ETHNICITY: (Circle One) Hispanic-Latino / Non- Hispanic-Latino / Unspecified

DISABLED: (Circle One) Yes / No

WORK STATUS: (Circle One) Unemployed-More than 6 Months / Unemployed-6 Months or Less /
Employed Full Time / Employed Part Time / Migrant Seasonal Worker /

HEALTH INSURANCE: (Circle One) None / Direct Purchase / Military / Medicare / Medicaid /
State Adult / State Children (ARKids) / Employment Based / Unspecified

LEGAL STATUS: (Circle One) Citizen / Legal Alien / Undocumented

MILITARY STATUS: (Circle One) Active / No Affiliation / Veteran / Unspecified

TOTAL NUMBER OF HOUSEHOLD MEMBERS: _____ # ADULTS: _____ # CHILDREN: _____

FAMILY TYPE: (Circle One) Extended Family / Multigenerational Household / Single /
Single Parent Female / Single Parent Male / 2 Adults no Children / 2 Parent Household /
Nonrelated Adults with Children / Other / Unspecified

HOUSING INFORMATION: (Circle One) Own / Rent / Other Permanent Housing / Homeless /
Temporary Quarters / Other / Unspecified

FAMILY INCOME:

Employment: Paycheck / TEA **Amount Received Monthly:** \$ _____

Benefit: SS / SS-SSI / SSA / SSD / SSI / VA **Amount Received Monthly:** \$ _____

Other: No-Income / Child Support / Family Contributions / SNAP / Interest / Pension / TANF /
Unemployment Benefits / Other **Amount Received Monthly:** \$ _____

COMMUNITY SERVICES OFFICE – HOUSEHOLD MEMBER INFORMATION

Complete chart for all Household members except Head of Household: (Please Print)

Name	Birthdate	Social Security Number	Relationship to Head of Household	Race	Ethnicity:	Sex	Education Level	Disabled: (Yes or No)	Veteran: (Yes or No)	Working or In School (Yes or No)	Type of Health Insurance	Monthly Income	Source of Income

Type of Assistance Requested: _____

I certify that the information provided on this application is correct. I understand that receipt of assistance through misrepresentation or fraud is punishable by fine or imprisonment.

Signature of Applicant: _____ Date: ____/____/____

Signature of CSO Personnel: _____ Date: ____/____/____

COMMUNITY SERVICES OFFICE – EMERGENCY SERVICES STATUS EVALUATION

In order to qualify for Emergency Assistance funds, you **MUST** be able to prove an *emergency* situation is occurring. Please provide proof of income, bills, and any papers you have to substantiate your claim.

Name: _____

Service Needed: (Circle One)

- Dental
- Electric Bill
- Emergency Lodging
- Gas Bill
- Medical
- Prescriptions
- Rent
- Water Bill
- Other: _____

Income & Expense Information:

Total Monthly Income: \$ _____ Source of Income: _____

Monthly Expenses:

- Cable/Satellite: \$ _____
- Car Insurance: \$ _____
- Child Care: \$ _____
- Electricity: \$ _____
- Garbage: \$ _____
- Gas Heating: \$ _____
- Groceries: \$ _____
- Home Insurance: \$ _____
- Internet: \$ _____
- Life Insurance: \$ _____
- Medical Bills: \$ _____
- Medical Insurance: \$ _____
- Phone: \$ _____
- Prescriptions: \$ _____
- Rent/Mortgage: \$ _____
- Vehicle: \$ _____
- Water: \$ _____
- Other: \$ _____

Office Use Only:

Viewed: (Circle all that Apply) Eviction Notice / Lease / Notice to Quit / Proof of Income / Receipts / RX / Other _____

Notes: _____

**COMMUNITY SERVICES OFFICE
CSBG FAMILY DEVELOPMENT PARTNERSHIP AGREEMENT**

Name: _____ **CSBG Case Number:** _____

Yes, I would like to participate in the CSBG Family Development activities offered through Community Services Office.

I understand that Family Development will include an application, client status evaluation, budget counseling, energy education, calls, and visits to your office as necessary to carry out the plan and goals agreed upon. I agree to actively strive toward self-sufficiency. In doing so, I agree to the following:

1. Providing my Family Development Worker with all the necessary and pertinent information regarding my case.
2. Keeping appointments when scheduled or calling ahead of appointments if they cannot be kept.
3. Developing a family budget.
4. Actively seeking employment (If necessary)

Client Signature: _____ Date: ____/____/____

Family Development Worker Signature: _____ Date: ____/____/____

**COMMUNITY SERVICES OFFICE
CSBG CLIENT NEEDS & STATUS EVALUATION**

Does the family have any needs in the areas of: (Circle all that Apply)

Income / Budgeting / Employment / Education or Training / Housing / Transportation / Health Care /
Child Care / Nutrition / Other _____

If you circled any of the above, please explain:

Does the family have a car?: (Circle one) Yes / No

If not, what transportation is available to the family?: _____

What are the immediate goals of the family?: _____

What are the long-term goals of the family?: _____

What are the family's strengths?: _____

Office Use Only:

Notes: _____

COMMUNITY SERVICES OFFICE - CLIENT ASSESSMENT SURVEY

Name: _____ Date: ____/____/____

AGENCY ASSISTANCE PROVIDED:

1. Have you received assistance from this agency before? (Circle one) Yes / No

SELF-SUFFICIENCY:

2. Did you consider yourself to be a self-sufficient individual prior to receiving services from this agency? (Circle one) Yes / No
3. Do you consider yourself to be more self-sufficient since participating in the services/activities offered by this agency? (Circle one) Yes / No
4. Has your net income increased since participating in the services/activities offered by this agency? (Circle one) Yes / No

IMPROVED CONDITIONS:

5. Do you believe the services/activities offered by this agency have improved your *living conditions*? (Circle one) Yes / No
6. If yes, how have your *living conditions* improved? _____

7. Has your home energy efficiency and/or energy burden been reduced since receiving services from this agency? (Circle one) Yes / No

STAKE IN THE COMMUNITY:

8. Do you feel you are a part of the community in which you live? (Circle one) Yes / No
9. If yes, in what way do you feel you are a part of the community? _____

10. Are you a part (participant or volunteer) of any community, religious, or social organizations where you live? (Circle one) Yes / No

FAMILY ACHIEVEMENT:

11. Has the *day-to-day functioning* of your family improved since you have been receiving services from this agency? (Circle one) Yes / No
12. If yes, what program or services do you feel helped your family to improve? _____
