DCED-CDBG-CV-021 (12/2020)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF COMMUNITY & ECONOMIC DEVELOPMENT
CENTER FOR COMMUNITY & HOUSING DEVELOPMENT

COVID-19
CERTIFICATION OF FAMILY ANNUAL INCOME

PURPOSE OF THE FORM

This is a written statement for individuals or families applying for **CDBG-CV assisted Direct Benefit activities.** The statement documents compliance with the specific COVID-19 related services being provided and the number of beneficiary members in the family/household. To complete this statement: report income being received or expected to be received on the date of completion. This statement and supporting documents must accompany the program administrator's application for assistance.

This form is applicable for CDBG-CV funded Subsistence / Emergency Payments public services activity.

CLIENT INFORMATION

1. NAME:		2. CLIENT ID:
3. ADDRESS: Municipality		
4. CITY:	5. STATE:	6. ZIP CODE:

For COVID-19/CARES Act:
The certification must indicate how the applicant's financial situation has changed, (i.e., job loss or reduced wages).

7. DESCRIBE LOSS/REDUCTION IN INCOME/HOURS OR OTHER APPLICABLE INFORMATION:

8. This certification includes all income, including any supplemental unemployment received by the individual /family as a result of the pandemic except for the emergency tax relief and unemployment benefits received as a result of COVID _____ (initials).

FAMILY INFORMATION

Enter all family member name(s) and date(s) of birth below.

Family Member #	Last Name	First Name & Middle Initial	Relationship to Head (e.g.: spouse, child, etc.)	Date of Birth (MM/DD/YYYY)	Disabled (Yes/No)	Student (Yes/No)
#1			Head			
#2						
#3						
#4						
#5						
#6						

FAMILY'S GROSS ANNUAL INCOME							
**All income sources of any kind should be gross, before taxes are taken out or reduction for either income or benefits.							
Source	**Frequency (week/ bi-weekly/ month/annual)**	**Family Member #1**	**Family Member #2**	**Family Member #3**	**Family Member #4**	**Family Member #5**	**Family Member #6**
Earned Income**							
Employer							
Net income from a business							
Benefit Income							
Annuities							
Disability/ Worker's Compensation							
Social Security							
Supplemental Security Income (SSI)							
Temporary Assistance to Needy Families (TANF)							
Veterans Administration (VA) Benefits							
Unemployment							
Other Income							
Alimony							
Child Support							
Retirement or Pension							
Adoption Assistance (count only the first $480)							
Trust							
Cash assistance from friends or family not residing in the household							
Other							
Totals							
TOTAL GROSS FAMILY INCOME: *(This total should reflect the projected ANNUAL/YEARLY earnings of all household members.)*	**$**						

DEMOGRAPHIC INFORMATION

1. RACE IDENTIFIERS:

☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander
☐ American Indian/Alaskan Native and White ☐ Asian and White ☐ Black/African American and White
☐ American Indian/Alaskan Native and African/American

☐ Other: _____ ☐ Other Multi-Racial: _____

2. DO YOU CONSIDER YOURSELF AS BEING OF HISPANIC ETHNICITY?

☐ Yes ☐ No

3. IS HEAD OF FAMILY DISABLED?	4. IS THE HEAD OF FAMILY FEMALE?
☐ Yes ☐ No	☐ Yes ☐ No

CERTIFICATION

I/we certify that this information is complete and accurate to the best of my knowledge.
I/we agree to provide, upon request, any additional documentation on all income sources to the Program Administrator.

HEAD OF HOUSEHOLD ADULT / FAMILY MEMBER #1		
SIGNATURE OF FAMILY MEMBER #1:	PRINTED NAME OF FAMILY MEMBER #1:	DATE:
OTHER BENEFICIARY ADULTS*		
SIGNATURE OF FAMILY MEMBER #2:	PRINTED NAME OF FAMILY MEMBER #2:	DATE:
SIGNATURE OF FAMILY MEMBER #3:	PRINTED NAME OF FAMILY MEMBER #3:	DATE:
SIGNATURE OF FAMILY MEMBER #4:	PRINTED NAME OF FAMILY MEMBER #4:	DATE:
SIGNATURE OF FAMILY MEMBER #5:	PRINTED NAME OF FAMILY MEMBER #5:	DATE:
SIGNATURE OF FAMILY MEMBER #6:	PRINTED NAME OF FAMILY MEMBER #6:	DATE:

* Attach another copy of this page if additional signature lines are required.

WARNING: The information provided on this form is subject to verification by HUD or DCED at any time, and Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony and assistance can be terminated for knowingly and willingly making a false or fraudulent statement to a department of the United States Government.

*** THIS PAGE TO BE COMPLETED BY SERVICE PROVIDER ADMINISTRATOR *** DETERMINATION OF INCOME ELIGIBILITY		
1. CURRENT FAMILY SIZE:	2. TOTAL ANNUAL FAMILY INCOME FROM ALL SOURCES:	
3. CURRENT HUD INCOME LIMIT*:	4. FAMILY MEETS THE FOLLOWING INCOME RESTRICTIONS: ☐ 50% ☐ 80% ☐ Over 80%	
SIGNATURE OF SERVICE PROVIDER ADMINISTRATOR		
Based on the representations herein and upon the information submitted, the individual(s) named on page one of this Certification is/are eligible under the provisions of the Cares Act for CDBG-CV funding.		
SIGNATURE OF SERVICE PROVIDER ADMINISTRATOR:	PRINTED NAME OF SERVICE PROVIDER ADMINISTRATOR:	DATE:
*Administrator is required to document the appropriate HUD Income Limits used in this determination.		

Traductores estarán disponibles en las reunions públicas por petición.

Übersetzer sind für die öffentliche Sitzung auf Anfrage erhältlich