# GREENE LAMP COMMUNITY ACTION
# COMMUNITY SERVICES BLOCK GRANT (CSBG) APPLICATION

NAME:______________________________________DATE:________________________

ADDRESS:_____________________________________________________________

HOME PHONE:__________ CELL PHONE:__________ SOCIAL SECURITY #:__________

ARE YOU CURRENTLY EMPLOYED?_______Yes _______No. IF YES,

EMPLOYER'S NAME AND ADDRESS:____________________________________________

_______________________________________TELEPHONE:_______________________

JOB TITLE:____________________PAY PER HOUR:_________HOURS PER WEEK:_________

MARITAL STATUS:__MARRIED,__SINGLE,__SEPARATED,__DIVORCED,__WIDOW(ER)

RACE:__BLACK,__WHITE,__HISPANIC,__NATIVE AMERICAN,__OTHER_______________

INCLUDING YOURSELF; LIST FAMILY MEMBERS IN HOUSEHOLD:

| NAME | DATE OF BIRTH | SEX M/F | SOCIAL SECURITY # | RELATIONSHIP TO HEAD | LEVEL OF EDUCATION/ LAST GRADE COMPLETED | INCOME SOURCE | HEALTH INSURANCE, MEDICARE, MEDICAID |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

TOTAL NUMBER IN HOUSEHOLD:____________________

OBTAINED CAREER READINESS CERTIFICATE?____YES____NO COMPLETION DATE__________

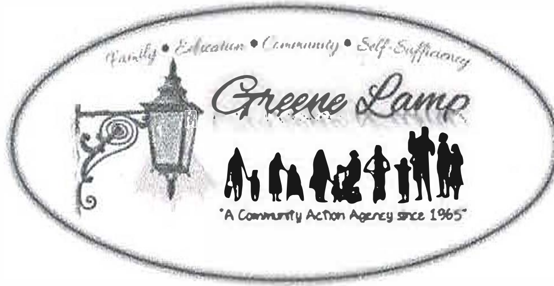
HAVE YOU EVER BEEN ENROLLED IN THE CSBG PROGRAM?_____YES_____NO

HAVE YOU EVER BEEN CONVICTED OF A FELONY?______YES______NO

I CURRENTLY RECEIVE THE FOLLOWING ASSISTANCE: (CHECK ALL THAT APPLY)

______FOOD STAMPS (Applicant Only) AMOUNT $______________
______AFDC/WFFA AMOUNT $______________
______CHILD CARE (DSS) AMOUNT $______________
______CHILD SUPPORT AMOUNT $______________
______NUTRITION/WIC AMOUNT $______________
______SOCIAL SECURITY/SSI AMOUNT $______________
______PUBLIC HOUSING AMOUNT $______________
______HUD/SECTION 8 AMOUNT $______________
______HUD UTILITY ASSISTANCE AMOUNT $______________
______UNEMPLOYMENT INSURANCE AMOUNT $______________

(FOR OFFICE USE ONLY)
APPLICANT'S ANNUAL INCOME: $________________
ANNUAL INCOME OF OTHER FAMILY MEMBERS: $________________
TOTAL ANNUAL FAMILY INCOME: $________________




# CHILD SUPPORT

**To: Department of Social Services**

**Return to: Greene Lamp, Inc.**
**Attention:**
**309 Summit Avenue**
**Kinston, NC 28501**
**Phone: (252) 523-7770**
**Fax: (252) 523-7868**

I, ____________________________, Social Security number ______-______-_______, hereby authorize the release of this information to the agency requesting it.

______________________________ ____________________
(Applicant's Signature) (Date)

**This section is to be filled out by the Department of Social Services**

The above applicant has applied for services. Please verify the applicant's participation in the child support program along with the amount received.

Child Name: __________________________ Amount: ___________________

Child Name: __________________________ Amount: ___________________

Child Name: __________________________ Amount: ___________________

Child Name: __________________________ Amount: ___________________

__________________________________________ ______________________
Signature of Authorized Agency Representative Date