



County of Imperial
CV-1 Subsistence Payments Program
Qualification and Instructions

Utility Assistance Types and Limits:

The program may pay the following types of utilities, for up to three months, with limited financial assistance amounts.

- Electricity - up to three months of service, limit of \$700.00 for the three months.
- Water, Sewer & Trash - up to three months of service with a financial limit of \$300.00 for the three months.
- Natural Gas - up to three months of service with a financial limit of \$100.00 for the 3 months.

Maximum amount of assistance per client/family \$1,100.00 for the three months. Cable, cell phone, internet services utilities are not eligible for this program.

Household income must be within the limits shown on the following page.

How to Apply

1. Complete and sign application.
2. Acceptable Identification (ID)
3. Past due bill and or notice of termination of services from the utility company.
4. Proof of lost job or reduction of hours due to Corona Virus Pandemic (COVID-19).
5. Signed Release of Information Form.

Return Completed application to:

County of Imperial Administration Building
County Executive Office
940 Main St. Suite 208
El Centro, CA. 92243

Monday–Friday 8:00am- 5:00 p.m.

For more information, please visit our website at www.imperialcounty.org.



County of Imperial
CV-19 Subsistence Payment Program Application

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

| | | |
|---|--------------------------|----------|
| Account Number (or name of mobile home park): | | |
| 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 _____

For more information, please visit our website at www.imperialcounty.org.

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) | | <input type="checkbox"/> Not Hispanic | <input type="checkbox"/> Hispanic |
| | | | |
| Race (Select One) | | | |
| <input type="checkbox"/> White | <input type="checkbox"/> Am. Indian/Alaskan Nat. & White | | |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Asian & White | | |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Black/African American & White | | |
| <input type="checkbox"/> American Indian/Alaskan Native | <input type="checkbox"/> Am. Indian/Alaskan & Black/African | | |
| <input type="checkbox"/> Nat. Hawaiian/Other Pacific Isl. | <input type="checkbox"/> Other Multi-Racial | | |
| | | | |
| Other Demographic Data (Select all that Applies) | | | |
| <input type="checkbox"/> Female Head of Household | <input type="checkbox"/> Single / Non Elderly | | |
| <input type="checkbox"/> Participant Disable | <input type="checkbox"/> Related/Single Parent | | |
| <input type="checkbox"/> Veteran | <input type="checkbox"/> Related/Two Parent | | |
| <input type="checkbox"/> Elderly | <input type="checkbox"/> 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: _____

Section 6932. 2021 Income Limits

| | | | | | | | | |
|--|----------|----------|----------|----------|----------|----------|----------|----------|
| Number of Persons in Household: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|--|----------|----------|----------|----------|----------|----------|----------|----------|

| | | | | | | | | | |
|--|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|
| Imperial County Area Median Income: \$70,700 | Extremely Low | 14700 | 17420 | 21960 | 26500 | 31040 | 35580 | 40120 | 44660 |
| | Very Low Income | 24500 | 28000 | 31500 | 34950 | 37750 | 40550 | 43350 | 46150 |
| | Low Income | 39150 | 44750 | 50350 | 55900 | 60400 | 64850 | 69350 | 73800 |



County of Imperial
Coronavirus Relief Fund Assistance Program

County Administration Building
County Executive Office
940 Main St., Suite 208
El Centro, CA. 92243

Authorization to Release Financial Information

I/We, _____, hereby
Name of Person(s) Giving Authorization

authorize the County of Imperial to obtain all needed information related to my Coronavirus Relief Fund Assistance Program application.

If required, I/we authorize mailing or faxing a copy of this release to other agencies to confirm my eligibility to the CV-19 Subsistence Payment Program. In addition, I understand that this form may be reproduced as needed, and a copy may serve as an original. This release shall only be valid for six months from the date of signature.

Participant

Co-participant

Date: _____

Date: _____

Name: _____

Name: _____

Address: _____

Address: _____

Mailing Address: _____

Mailing Address: _____

Phone #: _____

Phone #: _____

Social Security #: _____

Social Security #: _____

Date of Birth: _____

Date of Birth: _____

Signature _____

Signature _____