WILL COUNTY

CENTER FOR COMMUNITY CONCERNS

2455 GLENWOOD AVENUE, JOLIET, ILLINOIS 60435
PHONE: 815-722-0722 FAX: 815-722-6344

Scholarship Application

YOUR COMPLETED APPLICATION IS DUE BY: March 1, 2019

Dear Scholarship Applicant:

Thank you for your interest in the Community Services Block Grant Scholarship program. The maximum available per student this calendar year is $1,000.00. Payments will be made directly to your school. If you are approved for this scholarship, you will receive a notification letter which you take to your school so that they may bill the Agency. General information about scholarship recipients is used for publicity purposes. A publicity release certification is included right above the signature line on the enclosed application form.

In order to be considered for the Scholarship Program, you must provide the following documents. Incomplete applications will not be considered. If you have any questions please contact the office before submitting your application to ensure you are gathering all needed documentation.

- ✓ **Complete** Scholarship application forms
- ✓ **Complete** Information Referral sheets
- ✓ **Complete** Budget form. Monthly expense / cost
- ✓ **Complete** Zero Income Affidavit (for anyone in household that is age 18 yrs or older with no income anytime during the 90 days prior to application date)
- ✓ **Complete** Income Affidavit (for anyone 18 yrs or older with no income anytime during the 90 prior to application date), complete separate form for each household member that this form pertains to. If working for cash note amount received in the last 90 days.
- ✓ Copy of your Photo ID and Social Security Card
- ✓ Social Security Cards for all other members of your household
- ✓ Proof of your total household gross income (wages, SSI / SSA, unemployment, etc) for the 90 days prior to application date (the date application is submitted)
- ✓ If employment / income stopped within the last 120 days we will need proof of the last day of work and last check(s) received within the last 90 days.
- ✓ Unemployment printout is needed for anyone 18 yrs or older with no income
- ✓ Proof of benefits you have received from Dept. of Human Services (Public Aid) in the last 90 days (printout of SNAP amount (food stamps), medical card, etc.).
- ✓ Lease (complete with signature page),mortgage statement, property tax bill, or deed to verify residency.
- ✓ If already enrolled, please submit information from the college you are attending.

If there are any questions regarding this application, I can be reached at
(815) 722-0722, ext. 209.

Applications received after March 1, 2019 (4:00pm) will not be considered for review.

Sincerely,

Belithia Johnson

WILL COUNTY

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2455 GLENWOOD AVENUE, JOLIET, ILLINOIS 60435
PHONE: 815-722-0722   FAX: 815-722-6344

INSTRUCTIONS: Please type or print clearly. Answer all questions. **Incomplete applications will not be considered.**

________________________ Name of Applicant	____/____/____ Social Security Number
________________________ Address	____________ City ________ Zip
________________________ Phone #	________________________ Date of Birth

Name & Address of last high school attended:

________________________ School Name   ________________________ School Address

Did you graduate? ___Yes ___NO
If no, have you completed your G.E.D. ___Yes ___No

Name & Address of college choice:

________________________ School Name   ________________________ School Address

Dates you plan to be in attendance:

__________ __________ __________ __________

Expected date of graduation from college or certificate program__________________

Have you already applied? Yes ___No
Have you been accepted? ___Yes ___No
Do you already attend classes at chosen college? ___Yes ___No
Give brief description of what you plan to study including duration of the course(s) and what, if any, certificate or degree you will receive upon completion.

____

____

____

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List any financial assistance (school grants only) for which you have applied and indicate if each has been approved, denied, or pending:

____

____

List any other financial assistance for which you intend to apply in the future (for school only):

____

____

Please give a brief description of your financial need and the purposes for which a scholarship from Community Services Block Grant will be used.

____

____

____

____

____

____

By signing below, you certify that all the information contained in this application is true to the best of your knowledge. You also give permission for your name, city of residence, school name and course of study to be included in publicity materials related to the scholarship program.

______________________________ ______________
Signature Date

IMPORTANT
Please return the completed application and all required attachments to the address above. If your application is received after March 1, 2019 it may not be considered.

Please direct all questions and correspondence to Belithia Johnson (815) 722-0722 Ext. 209.

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COMMUNITY SERVICES BLOCK GRANT
SCHOLARSHIP SELECTION PROCESS

General Provisions

Applications will be considered on a first-come, first-served basis throughout the CSBG program year or until all scholarships are awarded.

If the original awardees do not utilize all available scholarship funds to the extent that at least $1,000 is left unused, we will advertise additional scholarship availability provided there is adequate time left to expend the funds during the current grant year.

There will be no holdover of applications for applicants who do not receive funding. They must reapply when funding comes available.

Qualifications

There is no upper age limit for recipients. Applicants who are still in high school must be seniors who have already been accepted to a post-secondary school and will start before the end of the CSBG grant year (December 31).

Recipients must qualify under the conditions set forth by the Community Services Block Grant in general, and the Work Program Format entitled "CSBG Scholarship Program" in particular. An attempt to establish financial aid need is also made.

Recipients must attend an accredited Illinois post-secondary institution.

Special Selection Criteria

Scholarships are processed and approved within 60 days from date of the deadline of application submission. In the event that more qualifying applications are received, a ranking system will be utilized to choose awardees.

APPLICATIONS RECEIVED AFTER DEADLINE MAY NOT BE CONSIDERED

All chosen applications are presented to the Will County Center for Community Concerns Board of Directors for final approval.

INFORMATION REFERRAL FORM

(PLEASE PRINT) Date ____________

ASSISTANCE NEEDED (circle all that apply):

LIHEAP Hardship/ComEd Water Homeless Services Housing Counseling Rent/Mortgage
Weatherization Car Repair Scholarship Food Basket Other: ____________

HEAD OF HOUSEHOLD:

SS# ______/_____/______ Date of Birth ____________ (MM / DD / YYYY) Age _____ Gender: ___ Male ___ Female ___ Other

First Name ____________ Last Name ____________ M.I.____ Suffix _____

Address ____________ Apt. _____ City____________ Zip _________

Township ____________ Phone (_____)______-________ Alternate Phone (_____)______-________

Email address ____________

Total # Persons Living in Household ____ (*complete HOUSEHOLD MEMBER INFORMATION FORM next page*)

Disabled __ Yes __ No Active Military __ Yes __ No Veteran __ Yes __ No

Health Insurance __ Yes __ No __ Medicaid __ Medicare __ Employer __ State __ Military __ Direct

Education: __ Gr 0-8 __ 9-12(non-grad) __ HS Diploma/GED __ 12+ Some post-secondary __ College Grad

FAMILY TYPE:

- ___ Foster parents
- ___ Multigenerational household
- ___ Non parent adult(s) with children
- ___ Single parent
- ___ Two parent family
- ___ Two or more related adults w/children
- ___ Single person
- ___ Two adults No children
- ___ Three or more adults No children
- ___ Other ____________

ETHNICITY

- ___ Hispanic/Latino
- ___ Non-Hispanic/Latino

RACE:

- ___ American Indian
- ___ Alaskan Native
- ___ Asian/Pacific Islander
- ___ Black or African American
- ___ Multi-Race (any 2 or more)
- ___ White
- ___ Other ____________

LANGUAGE:

- ___ English
- ___ Spanish
- ___ Chinese
- ___ Japanese
- ___ Polish
- ___ Arabic
- ___ Tagalog
- ___ French
- ___ German
- ___ Sign language

HOUSING STATUS:

__ Renting – amount $__________ per month. Subsidized? __ Yes __ No Number months past due ____

__ Owns home – amount $__________ Number months past due ____

__ Living with family __ Living with friend __ Nursing home __ Domestic Violence Situation

__ Treatment center __ Emergency shelter __ Transitional housing __ Jail/Prison

__ Homeless (on the street) __ Other ____________

Are you currently working? __ Yes __ No __ Retired

If Yes, __ Full Time (over 35 hours) __ Part Time (1 to 35 hours) Hours/Week ____ Hourly Wage $_______

Farmer __ Yes __ No Migrant seasonal farm worker __ Yes __ No Seasonal __ Yes __ No

If No, Unemployed: __ 6 months or less __ More than 6 months __ Not in work force __ Unable

Describe unable to work due to: __ Am a Caregiver __ Disabled __ Senior __ Transportation

SOURCE OF HOUSEHOLD MONTHLY INCOME:

TANF $__________ Pension $__________ Workers Compensation $__________

SSI $__________ Unemployment Insurance $__________ VA Svc Disability Compensation $__________

SSDI $__________ Child Support $__________ VA Non-Svc Disability Pension $__________

SSA $__________ Alimony/Spousal Support $__________ Retirement from Soc Sec $__________

EITC $__________ Private Disability $__________ Other __________ $__________

Food Stamps __ Yes __ No **TOTAL HOUSEHOLD INCOME FOR 90 DAYS $__________**

ADDITIONAL HOUSEHOLD MEMBERS INFORMATION (*in relation to Head of Household* "HOH"): **(Pg.2)**

First Name ____________ Last Name ____________ M.I.____ Suffix _____
Relationship to HOH ____________ DOB ____________ SS# ______/_____/______
Gender: __ Male __ Female __ Other Ethnicity ____________ Disabled __ Yes __ No
Education level __________ Food Stamps __ Yes __ No
Disconnected Youth – Is child between ages 14 and 18, not in school, and not working? __ Yes __ No
Health Insurance __ Yes __ No __ Medicaid __ Medicare __ Employer __ State __ Military __ Direct
Veteran Yes / No Farmer Yes / No Income Source ____________ Amount $________

First Name ____________ Last Name ____________ M.I.____ Suffix _____
Relationship to HOH ____________ DOB ____________ SS# ______/_____/______
Gender: __ Male __ Female __ Other Ethnicity ____________ Disabled __ Yes __ No
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Veteran Yes / No Farmer Yes / No Income Source ____________ Amount $________

Application Affirmation and Authorization to Verify Information

Application statement: I certify that the above information is an accurate and complete disclosure of the requested information. I hereby acknowledge that the information relating to determination of my eligibility requires verification and/or documentation, and by my signature, I authorize others to release such information as may be required for the determination of my edibility.

☐ I understand all income sources, for all household members, will be further verified by the State of Illinois.

Signature of Applicant: ____________________ Date __________

If other than Applicant, print name and relation: ____________________

CSR Signature and Printed Name ____________________ Date __________

ADDITIONAL HOUSEHOLD MEMBERS INFORMATION (*in relation to Head of Household* "HOH"):

First Name ____________________ Last Name ____________________ M.I.____ Suffix _____
Relationship to HOH ____________________ DOB ______________ SS# ______/______/______
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Disconnected Youth – Is child between ages 14 and 18, not in school, and not working? __ Yes __ No
Health Insurance __ Yes __ No __ Medicaid __ Medicare __ Employer __ State __ Military __ Direct
Veteran Yes / No Farmer Yes / No Income Source ____________________ Amount $________

MONTHLY FAMILY BUDGET

NAME:______________________________ # In Household____________________

Period Budgeted:________________________________ to____________________________

BASIC MONTHLY EXPENSES

Groceries	$__________
Rent / Mortgage	$__________
Gas	$__________
Electric	$__________
Water	$__________
Telephone	$__________
Clothing	$__________
Laundry	$__________
Auto Insurance	$__________
Auto / Gas	$__________
Medical Expense	$__________
Day Care	$__________
Church / Contributions	$__________
Daily Expenses (Transport, Meals, Etc.)	$__________
Child Support	$__________
Entertainment (Cable, Movies, Etc.)	$__________
Hygiene / Grooming	$__________
Home Repair	$__________
Other	$__________

TOTAL EXPENSES $__________

TOTAL EXPENSES PAID $__________

LOAN / INSTALLMENT PAYMENTS / DEBTS

Loan #1	$__________
Loan #2	$__________
Loan #3	$__________
Loan #4	$__________
Inst. Acct.	$__________
Inst. Acct.	$__________
Inst. Acct.	$__________
Inst. Acct.	$__________
Medical	$__________
Collections	$__________
Collections	$__________
Other	$__________
Other	$__________

TOTAL PRIMARY DEBTS $__________

INCOME/TAKE HOME PAY (MONTHLY)

Full-time Employment #1	$__________
Full-time Employment #2	$__________
Part-time Employment	$__________
Social Security	$__________
SSI	$__________
TANF	$__________
Child Support / Alimony	$__________
Retirement	$__________
Unemployment	$__________
Other Income	$__________

TAKE HOME PAY $__________

SUMMARY OF FINANCIAL STATUS

A. BASIC EXPENSES PAID $__________

B. DEBTS PAID $__________

TOTAL EXPENSES PAID (A + B)$__________

Subtract expenses from take home pay.

Amount left after all expenses are paid $__________

CREDITOR	$ PAYMENT	#DELINQUENT	BALANCE

Client Services Representative

____

ZERO INCOME AFFIDAVIT
CSBG

Application Date ________________ Applicant Name ______________________________

I, ____, attest to the fact that adult members of my household have received zero income for the period covering

________________ through ______________________.

Family Member Name	Relationship	Last Employer	Last Day Worked	Age

Please list the amount of money received to cover these monthly expenses and the name, address and phone number of those who assisted you.

Expense	Amount
Rent	$
Food	$
Heat	$
Electricity	$
Water	$
Transportation	$
Loans	$
Miscellaneous	$
Total monthly expense	$
90 day total expenses	**$**

The above financial obligations were met during the reporting period by:

____

____

____

____

I understand that to perjure myself in order to obtain assistance is a fraudulent offense for which I can be prosecuted.

______________________________ ____________
Signature of Applicant Date

______________________________ ____________
Witnessed by Date

MUST BE RETURNED BY ______________________

COMMUNITY SERVICE BLOCK GRANT PROGRAM

INCOME AFFIDAVIT

I, ____________________ attest to the fact I have received $ ________ gross income for the period covering ______________ to ___________________.

I met my financial obligations during the 30-day period by:

____

____

____

____

I understand that to perjure myself in order to obtain assistance is a fraudulent offense for which I can be prosecuted.

____

____________________________ ____________
Signature Date

____
Social Security Number

____
Name of Head of Household

____
Street Address

____________________________ ____________ ____________
City State Zip

____________________________ ____________
Witnessed by Date