

**TOWN/CITY OF \_\_\_\_\_**  
**BENEFIT DATA INFORMATION SHEET**  
 ANDROSCOGGIN COUNTY (Uses Lewiston/Auburn MSA limits)

Date: \_\_\_\_\_

CDBG PROGRAM TYPE \_\_\_\_\_

The Town/City of \_\_\_\_\_ is currently preparing an application for Community Development Block Grant (CDBG) funds from the State of Maine, Department of Economic and Community Development. The proposed activities are to: \_\_\_\_\_

For the proposed activities, the CDBG program requires proof of providing benefit to low and moderate-income persons. Therefore, the community is surveying the potential beneficiaries to ensure compliance with the regulations of the CDBG Program.

Your response to the following questions is critical in finalizing the application process. All responses will be kept confidential and used solely for securing CDBG grant funds.

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Name (optional): \_\_\_\_\_ Survey # \_\_\_\_\_

Address: \_\_\_\_\_

Please place an "X" in the appropriate spaces pertaining to your family's size, annual income and makeup.  
**\*In determining total family income use your total gross income for the 12 month period prior to completing this form.\***

**FAMILY SIZE INCOME**

1	\$39,150	Above _____	Below _____
2	44,750	Above _____	Below _____
3	50,350	Above _____	Below _____
4	55,900	Above _____	Below _____
5	60,400	Above _____	Below _____
6	64,850	Above _____	Below _____
7	69,350	Above _____	Below _____
8	73,800	Above _____	Below _____

**BENEFICIARY INFORMATION:**

**Family Race:** Indicate by putting a number on the appropriate line

White \_\_\_\_\_ Black/African American \_\_\_\_\_ Asian \_\_\_\_\_ American Indian/Alaskan Native \_\_\_\_\_  
 Native Hawaiian/Other Pacific Islander \_\_\_\_\_ American Indian/Alaskan Native & White \_\_\_\_\_  
 Asian & White \_\_\_\_\_ Black/African American & White \_\_\_\_\_  
 American Indian/Alaskan Native & Black/African American \_\_\_\_\_

**Family Make-up:** Enter number of elderly or severely disabled family members and indicate with an "X" if a female head of household is present

Number of Elderly: \_\_\_\_\_  
 Number of Severely Disabled: \_\_\_\_\_  
 Female Head of Household: \_\_\_\_\_ Yes \_\_\_\_\_ No

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TO BE FILLED OUT BY INDEPENDENT VERIFIER: LMI \_\_\_\_\_ NON-LMI \_\_\_\_\_

\_\_\_\_\_  
 Signature of authorized official Date