TOWN/CITY OF
BENEFIT DATA INFORMATION SHEET
KNOX COUNTY

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.

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 $38,200 Above _____ Below _____
2 43,650 Above _____ Below _____
3 49,100 Above _____ Below _____
4 54,550 Above _____ Below _____
5 58,950 Above _____ Below _____
6 63,300 Above _____ Below _____
7 67,650 Above _____ Below _____
8 72,050 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 _____ Other _____

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

---------------------------------------------------------TO BE FILLED OUT BY INDEPENDENT VERIFIER: LMI _____ NON LMI _____

Signature of authorized official ____________________________ Date ____________________________

Revised 4/2020

Effective 4/1/2020