

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.

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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 | \$39,450 | Above _____ | Below _____ |
| 2 | 45,050 | Above _____ | Below _____ |
| 3 | 50,700 | Above _____ | Below _____ |
| 4 | 56,300 | Above _____ | Below _____ |
| 5 | 60,850 | Above _____ | Below _____ |
| 6 | 65,350 | Above _____ | Below _____ |
| 7 | 69,850 | Above _____ | Below _____ |
| 8 | 74,350 | 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