

**BENEFIT DATA INFORMATION SHEET**  
AROOSTOOK 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	\$36,300	Above	_____	Below	_____
2	41,500	Above	_____	Below	_____
3	46,700	Above	_____	Below	_____
4	51,850	Above	_____	Below	_____
5	56,000	Above	_____	Below	_____
6	60,150	Above	_____	Below	_____
7	64,300	Above	_____	Below	_____
8	68,450	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 \_\_\_\_\_