TOWN/CITY OF ____________________
BENEFIT DATA INFORMATION SHEET
SOMERSET 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: ____
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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
<u>*In determining total family income use your total gross income for the 12 month period prior to completing this form.*</u>

FAMILY SIZE	INCOME		
1	$ 37,700	Above _____	Below ______
2	43,100	Above _____	Below ______
3	48,500	Above _____	Below ______
4	53,850	Above _____	Below ______
5	58,200	Above _____	Below ______
6	62,500	Above _____	Below ______
7	66,800	Above _____	Below ______
8	71,100	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 _____

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TO BE FILLED OUT BY INDEPENDENT VERIFIER: LMI ____ NON LMI ____

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Signature of authorized official Date

Revised 4/2020

Effective 4/1/2020