TOWN/CITY OF
BENEFIT DATA INFORMATION SHEET
WASHINGTON 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.*

<table>
<thead>
<tr>
<th>FAMILY SIZE</th>
<th>INCOME</th>
<th>Above</th>
<th>Below</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$37,700</td>
<td></td>
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<tr>
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<tr>
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<tr>
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</tr>
<tr>
<td>7</td>
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</tr>
<tr>
<td>8</td>
<td>71,100</td>
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</tbody>
</table>

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 _____

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

Signature of authorized official __________________ Date __________

Revised 4/2020

Effective 4/1/2020