

WILL COUNTY

CENTER FOR COMMUNITY CONCERNS

2455 GLENWOOD AVENUE, JOLIET, ILLINOIS 60435

PHONE: 815-722-0722

FAX: 815-722-6344

Scholarship Application

YOUR COMPLETED APPLICATION IS DUE BY: February 26, 2024

Dear Scholarship Applicant:

Thank you for your interest in the Community Services Block Grant Scholarship program. Funding is provided by the Department of Commerce Economic Opportunity. The maximum available per student this calendar year is \$1,000.00. Payments will be made directly to your educational institution. If you are approved for this scholarship, you will receive a notification letter which you take to your school so that they may bill the Agency. General information about scholarship recipients is used for publicity purposes. A publicity release certification is included right above the signature line on the enclosed application form.

In order to be considered for the Scholarship Program, **you must complete all pages of the attached forms and submit all the required documentation list below and reside in Will County.** Incomplete applications will not be considered. If you have any questions please contact the office before submitting your application to ensure you are gathering all needed documentation.

- ✓ **Complete** Scholarship application forms
- ✓ **Complete** Information Referral sheets
- ✓ **Complete** Universal Signature Page
- ✓ **Complete** Budget form. Monthly expense / cost
- ✓ **Complete** Zero Income Affidavit (for anyone in household that is age 18 yrs or older with no income anytime during the 60 days prior to application date)
- ✓ **Complete** Income Affidavit (for anyone 18 yrs or older with no income anytime during the 60 prior to application date), complete separate form for each household member that this form pertains to. If working for cash note amount received in the last 0 days.
- ✓ Copy of your Photo ID and Social Security Card
- ✓ Social Security Cards for all other members of your household
- ✓ Proof of your total household gross income (wages, SSI / SSA, unemployment, etc) for the 30 days prior to application date (the date application is submitted)
- ✓ If employment / income stopped within the last 60 days we will need proof of the last day of work and last check(s) received within the last 60 days.
- ✓ Unemployment printout is needed for anyone 18 yrs or older with no income
- ✓ Proof of benefits you have received from Dept. of Human Services (Public Aid) (printout of SNAP amount (food stamps), medical card, etc.). "Notice of Decision"
- ✓ Lease (complete with signature page), mortgage statement, property tax bill, deed, and/or utility bill to verify residency. **MUST BE A WILL COUNTY RESIDENT.**
- ✓ If already enrolled, please submit information from the college you are attending.

If there are any questions regarding this application, I can be reached at (815) 722-0722, ext. 2209.

Applications received after February 26, 2024 (3:30pm) will not be considered for review.

Sincerely,
Belithia Johnson

WILL COUNTY

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2455 GLENWOOD AVENUE, JOLIET, ILLINOIS 60435

PHONE: 815-722-0722 FAX: 815-722-6344

INSTRUCTIONS: Please type or print clearly. Answer all questions. **Incomplete applications will not be considered.**

_____	_____/_____/_____ Social Security Number	
_____	_____	_____
Address	City	Zip
_____	_____	
Phone #	Date of Birth	

Name & Address of last high school attended:

_____ School Name _____ School Address

Did you graduate? ___ Yes ___ NO
If no, have you completed your G.E.D. ___ Yes ___ No

Name & Address of college choice:

_____ School Name _____ School Address

Dates you plan to be in attendance:

Expected date of graduation from college or certificate program _____

Have you already applied? ___ Yes ___ No
Have you been accepted? ___ Yes ___ No
Do you already attend classes at chosen college? ___ Yes ___ No

Give brief description of what you plan to study including duration of the course(s) and what, if any, certificate or degree you will receive upon completion.

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List any financial assistance (school grants only) for which you have applied and indicate if each has been approved, denied, or pending:

List any other financial assistance for which you intend to apply in the future (for school only):

Please give a brief description of your financial need and the purposes for which a scholarship from Community Services Block Grant will be used.

By signing below, you certify that all the information contained in this application is true to the best of your knowledge. You also give permission for your name, city of residence, school name and course of study to be included in publicity materials related to the scholarship program.

Signature _____
Date

IMPORTANT
Please return the completed application and all required attachments to the address above. If your application is received after February 26, 2024 it may not be considered.

Please direct all questions and correspondence to Belithia Johnson (815) 722-0722 Ext. 2209.

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**COMMUNITY SERVICES BLOCK GRANT
SCHOLARSHIP SELECTION PROCESS**

General Provisions

Applications will be considered on a first-come, first-served basis throughout the CSBG program year or until all scholarships are awarded.

If the original awardees do not utilize all available scholarship funds to the extent that at least \$1,000 is left unused, we will advertise additional scholarship availability provided there is adequate time left to expend the funds during the current grant year.

There will be no holdover of applications for applicants who do not receive funding. They must reapply when funding comes available.

Qualifications

There is no upper age limit for recipients. Applicants who are still in high school must be seniors who have already been accepted to a post-secondary school and will start before the end of the CSBG grant year (December 31).

Recipients must qualify under the conditions set forth by the Community Services Block Grant in general, and the Work Program Format entitled "CSBG Scholarship Program" in particular. An attempt to establish financial aid need is also made.

Recipients must attend an accredited post-secondary institution.

Special Selection Criteria

Scholarships are processed and approved within 60 days from date of the deadline of application submission. In the event that more qualifying applications are received, a ranking system will be utilized to choose awardees.

APPLICATIONS RECEIVED AFTER DEADLINE MAY NOT BE CONSIDERED

All chosen applications are presented to the Will County Center for Community Concerns Board of Directors for final approval, which takes place in March.

An approval or denial letter will be sent to all applicants by the end March.

INFORMATION REFERRAL FORM

(PLEASE PRINT)

Date _____

ASSISTANCE NEEDED (circle all that apply):

LIHEAP Hardship/ComEd Water Homeless Services Housing Counseling Rent/Mortgage
 Weatherization Car Repair Scholarship Food Basket Other: _____

HEAD OF HOUSEHOLD:

SS# _____ / _____ / _____ Date of Birth _____ Age _____ Gender: Male
 Female
 Other
(MM / DD / YYYY)

First Name _____ Last Name _____ M.I. _____ Suffix _____

Address _____ Apt. _____ City _____ Zip _____

Township _____ Phone (_____) _____ - _____ Alternate Phone (_____) _____ - _____

Email address _____

Total # Persons Living in Household _____ (complete HOUSEHOLD MEMBER INFORMATION FORM next page)

Disabled Yes No Active Military Yes No Veteran Yes No

Health Insurance Yes No Medicaid Medicare Employer State Military Direct

Education: Gr 0-8 9-12(non-grad) HS Diploma/GED 12+ Some post-secondary College Grad

FAMILY TYPE:

Foster parents
 Multigenerational household
 Non parent adult(s) with children
 Single parent
 Two parent family
 Two or more related adults w/children
 Single person
 Two adults No children
 Three or more adults No children
 Other _____

ETHNICITY

Hispanic/Latino
 Non-Hispanic/Latino
RACE:
 American Indian
 Alaskan Native
 Asian/Pacific Islander
 Black or African American
 Multi-Race (any 2 or more)
 White
 Other _____

LANGUAGE:

English
 Spanish
 Chinese
 Japanese
 Polish
 Arabic
 Tagalog
 French
 German
 Sign language

HOUSING STATUS:

Renting – amount \$ _____ per month. Subsidized? Yes No Number months past due _____

Owns home – amount \$ _____ Number months past due _____

Living with family Living with friend Nursing home Domestic Violence Situation

Treatment center Emergency shelter Transitional housing Incarcerated

Homeless (on the street) Other _____

Are you currently working? Yes No Retired

If Yes, Full Time (over 35 hours) Part Time (1 to 35 hours) Hours/Week _____ Hourly Wage \$ _____

Farmer Yes No Migrant seasonal farm worker Yes No Seasonal Yes No

If No, Unemployed: 6 months or less More than 6 months Not in work force Unable

Describe unable to work due to: Am a Caregiver Disabled Senior Transportation

SOURCE OF HOUSEHOLD MONTHLY INCOME:

TANF \$ _____ Pension \$ _____ Workers Compensation \$ _____
SSI \$ _____ Unemployment Insurance \$ _____ VA Svc Disability Compensation \$ _____
SSDI \$ _____ Child Support \$ _____ VA Non-Svc Disability Pension \$ _____
SSA \$ _____ Alimony/Spousal Support \$ _____ Retirement from Soc Sec \$ _____
EITC \$ _____ Private Disability \$ _____ Other _____ \$ _____

Food Stamps Yes No **TOTAL HOUSEHOLD INCOME FOR 90 DAYS \$ _____**

ADDITIONAL HOUSEHOLD MEMBERS INFORMATION (in relation to Head of Household "HOH"): (Pg.2)

First Name _____ Last Name _____ M.I. _____ Suffix _____
Relationship to HOH _____ DOB _____ SS# _____ / _____ / _____
Gender: __ Male __ Female __ Other Ethnicity _____ Disabled __ Yes __ No
Education level _____ Food Stamps __ Yes __ No
Disconnected Youth – Is child between ages 14 and 18, not in school, and not working? __ Yes __ No
Health Insurance __ Yes __ No __ Medicaid __ Medicare __ Employer __ State __ Military __ Direct
Veteran Yes / No Farmer Yes / No Income Source _____ Amount \$ _____

First Name _____ Last Name _____ M.I. _____ Suffix _____
Relationship to HOH _____ DOB _____ SS# _____ / _____ / _____
Gender: __ Male __ Female __ Other Ethnicity _____ Disabled __ Yes __ No
Education level _____ Food Stamps __ Yes __ No
Disconnected Youth – Is child between ages 14 and 18, not in school, and not working? __ Yes __ No
Health Insurance __ Yes __ No __ Medicaid __ Medicare __ Employer __ State __ Military __ Direct
Veteran Yes / No Farmer Yes / No Income Source _____ Amount \$ _____

First Name _____ Last Name _____ M.I. _____ Suffix _____
Relationship to HOH _____ DOB _____ SS# _____ / _____ / _____
Gender: __ Male __ Female __ Other Ethnicity _____ Disabled __ Yes __ No
Education level _____ Food Stamps __ Yes __ No
Disconnected Youth – Is child between ages 14 and 18, not in school, and not working? __ Yes __ No
Health Insurance __ Yes __ No __ Medicaid __ Medicare __ Employer __ State __ Military __ Direct
Veteran Yes / No Farmer Yes / No Income Source _____ Amount \$ _____

First Name _____ Last Name _____ M.I. _____ Suffix _____
Relationship to HOH _____ DOB _____ SS# _____ / _____ / _____
Gender: __ Male __ Female __ Other Ethnicity _____ Disabled __ Yes __ No
Education level _____ Food Stamps __ Yes __ No
Disconnected Youth – Is child between ages 14 and 18, not in school, and not working? __ Yes __ No
Health Insurance __ Yes __ No __ Medicaid __ Medicare __ Employer __ State __ Military __ Direct
Veteran Yes / No Farmer Yes / No Income Source _____ Amount \$ _____

Application Affirmation and Authorization to Verify Information

Application statement: I certify that the above information is an accurate and complete disclosure of the requested information. I hereby acknowledge that the information relating to determination of my eligibility requires verification and/or documentation, and by my signature, I authorize others to release such information as may be required for the determination of my edibility.

I understand all income sources, for all household members, will be further verified by the State of Illinois.

Signature of Applicant: _____ Date _____

If other than Applicant, print name and relation: _____

CSR Signature and Printed Name _____ Date _____

ADDITIONAL HOUSEHOLD MEMBERS INFORMATION (in relation to Head of Household "HOH"): **(Pg.3)**

First Name _____ Last Name _____ M.I. _____ Suffix _____
Relationship to HOH _____ DOB _____ SS# _____ / _____ / _____
Gender: Male Female Other Ethnicity _____ Disabled Yes No
Education level _____ Food Stamps Yes No
Disconnected Youth – Is child between ages 14 and 18, not in school, and not working? Yes No
Health Insurance Yes No Medicaid Medicare Employer State Military Direct
Veteran Yes / No Farmer Yes / No Income Source _____ Amount \$ _____

First Name _____ Last Name _____ M.I. _____ Suffix _____
Relationship to HOH _____ DOB _____ SS# _____ / _____ / _____
Gender: Male Female Other Ethnicity _____ Disabled Yes No
Education level _____ Food Stamps Yes No
Disconnected Youth – Is child between ages 14 and 18, not in school, and not working? Yes No
Health Insurance Yes No Medicaid Medicare Employer State Military Direct
Veteran Yes / No Farmer Yes / No Income Source _____ Amount \$ _____

First Name _____ Last Name _____ M.I. _____ Suffix _____
Relationship to HOH _____ DOB _____ SS# _____ / _____ / _____
Gender: Male Female Other Ethnicity _____ Disabled Yes No
Education level _____ Food Stamps Yes No
Disconnected Youth – Is child between ages 14 and 18, not in school, and not working? Yes No
Health Insurance Yes No Medicaid Medicare Employer State Military Direct
Veteran Yes / No Farmer Yes / No Income Source _____ Amount \$ _____

First Name _____ Last Name _____ M.I. _____ Suffix _____
Relationship to HOH _____ DOB _____ SS# _____ / _____ / _____
Gender: Male Female Other Ethnicity _____ Disabled Yes No
Education level _____ Food Stamps Yes No
Disconnected Youth – Is child between ages 14 and 18, not in school, and not working? Yes No
Health Insurance Yes No Medicaid Medicare Employer State Military Direct
Veteran Yes / No Farmer Yes / No Income Source _____ Amount \$ _____

First Name _____ Last Name _____ M.I. _____ Suffix _____
Relationship to HOH _____ DOB _____ SS# _____ / _____ / _____
Gender: Male Female Other Ethnicity _____ Disabled Yes No
Education level _____ Food Stamps Yes No
Disconnected Youth – Is child between ages 14 and 18, not in school, and not working? Yes No
Health Insurance Yes No Medicaid Medicare Employer State Military Direct
Veteran Yes / No Farmer Yes / No Income Source _____ Amount \$ _____

Universal Signature Page

IMPORTANT NOTICE: This state of Illinois grantee agency, _____, is requesting disclosure of information that is necessary to accomplish a complete application for:

<input checked="" type="checkbox"/>	Community Service Block Grant (CSBG)
<input type="checkbox"/>	Illinois Home Weatherization Assistance Program (IHWAP or Weatherization)
<input type="checkbox"/>	Low Income Home Energy Assistance Program (LIHEAP or Energy Assistance), including the Percentage of Income Payment Plan (PIPP) program

APPLICANT STATEMENT: I certify that the information I have provided is an accurate and complete disclosure of the requested information. I also certify that every household member in the application is a resident of Illinois.

I authorize this agency to verify the information and contact my utility/fuel supplier, landlord, employer and/or other sources for verification or additional information and to exchange information contained in or otherwise used regarding my application and participation in CSBG/LIHEAP/IHWAP.

For LIHEAP and IHWAP I also authorize the Department of Commerce & Economic Opportunity and my utility/fuel supplier to share my usage and bill information during the twenty-four (24) month period prior to and twelve (12) month period after the date of my application submittal and/or completion of LIHEAP and IHWAP services for the purpose of program evaluation and analysis.

I have received information outlining my appeal rights. I understand that filling out this application does not guarantee that my household will receive assistance. I understand I will be provided a copy of this application for my future reference.

Applicant Name: _____

Applicant Signature: _____ **Date:** _____

MONTHLY FAMILY BUDGET

NAME: _____

In Household _____

Period Budgeted: _____ to _____

BASIC MONTHLY EXPENSES

Groceries \$ _____
Rent / Mortgage \$ _____
Gas \$ _____
Electric \$ _____
Water \$ _____
Telephone \$ _____
Clothing \$ _____
Laundry \$ _____
Auto Insurance \$ _____
Auto / Gas \$ _____
Medical Expense \$ _____
Day Care \$ _____
Church / Contributions \$ _____
Daily Expenses (Transport, Meals, Etc.) \$ _____
Child Support \$ _____
Entertainment \$ _____
(Cable, Movies, Etc.) \$ _____
Hygiene / Grooming \$ _____
Home Repair \$ _____
Other \$ _____

TOTAL EXPENSES \$ _____

TOTAL EXPENSES PAID \$ _____

LOAN / INSTALLMENT PAYMENTS / DEBTS

Loan #1 \$ _____
Loan #2 \$ _____
Loan #3 \$ _____
Loan #4 \$ _____
Inst. Acct. \$ _____
Inst. Acct. \$ _____
Inst. Acct. \$ _____
Inst. Acct. \$ _____
Medical \$ _____
Collections \$ _____
Collections \$ _____
Other \$ _____
Other \$ _____

TOTAL PRIMARY DEBTS \$ _____

INCOME/TAKE HOME PAY (MONTHLY)

Full-time Employment #1 \$ _____
Full-time Employment #2 \$ _____
Part-time Employment \$ _____
Social Security \$ _____
SSI \$ _____
TANF \$ _____
Child Support / Alimony \$ _____
Retirement \$ _____
Unemployment \$ _____
Other Income \$ _____

TAKE HOME PAY \$ _____

SUMMARY OF FINANCIAL STATUS

A. BASIC EXPENSES PAID \$ _____

B. DEBTS PAID \$ _____

TOTAL EXPENSES PAID (A + B) \$ _____

Subtract expenses from take home pay.

Amount left after all expenses are paid \$ _____

CREDITOR \$ PAYMENT #DELINQUENT BALANCE

Client Services Representative

**ZERO INCOME AFFIDAVIT
CSBG**

Application Date _____ Applicant Name _____

I, _____, attest to the fact that adult members of my household have received zero income for the period covering _____ through _____.

Family Member Name	Relationship	Last Employer	Last Day Worked	Age

Please list the amount of money received to cover these monthly expenses and the name, address and phone number of those who assisted you.	Expense	Amount
	Rent	\$ _____
	Food	\$ _____
	Heat	\$ _____
	Electricity	\$ _____
	Water	\$ _____
	Transportation	\$ _____
	Loans	\$ _____
	Miscellaneous	\$ _____
	Total monthly expense	\$ _____
30 day total expenses		\$ _____

The above financial obligations were met during the reporting period by:

I understand that to perjure myself in order to obtain assistance is a fraudulent offense for which I can be prosecuted.

Signature of Applicant

Date

Witnessed by

Date

MUST BE RETURNED BY _____

COMMUNITY SERVICE BLOCK GRANT PROGRAM

INCOME AFFIDAVIT

I, _____ attest to the fact I have received \$ _____ gross income
for the period covering _____ to _____.

I met my financial obligations during the 30-day period by:

I understand that to perjure myself in order to obtain assistance is a fraudulent offense
for which I can be prosecuted.

Signature

Date

Social Security Number

Name of Head of Household

Street Address

City

State

Zip

Witnessed by Date
