



## Rent/Mortgage Assistance Application (CSBG/FEMA)

**Documentation Needed:**

- A valid picture of identification for the head of the household
- Social Security cards for every household member
- Proof of income for every household member. Household reporting zero income must provide additional documentation.
- Copy of FULL lease and late rent/eviction letter.
- Copies of proof of payment of all bills that you pay on a monthly basis (rent/mortgage, electricity, water, phone, cable, car note/insurance, gas, credit card bill(s)).

**If all required documents are not included, your application will be determined incomplete and you will need to re-apply.**

**Applicant Information:**

CSBG

FEMA

<b>First name(required)</b>		<b>Last name(required)</b>	
<b>Gender(required)</b> <input type="checkbox"/> Female <input type="checkbox"/> Trans Female (MTF) <input type="checkbox"/> Male <input type="checkbox"/> Trans Male (FTM)		<b>Date of Birth(required)</b>	<b>SSN(required)</b>
<b>Race(required)</b> <input type="checkbox"/> Black, African American <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Other _____		<b>Primary Language(required)</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Other _____	<b>Citizen(required)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Ethnicity(required)</b> <input type="checkbox"/> Hispanic, Latino or Spanish Origins <input type="checkbox"/> Not Hispanic, Latino or Spanish Origins			<b>Veteran(required)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Street address(This is where you receive energy/water service) (required)</b>		<b>Apartment/Unit(if applicable)</b>	
<b>City(required)</b>		<b>State(required)</b>	<b>Zip code(required)</b>
<b>Phone Number(one # required)</b> <input type="checkbox"/> Mobile _____ <input type="checkbox"/> Home _____		<b>Email Address(optional)</b>	
<b>Disability(required)</b>	<b>Marital Status(required)</b>	<b>Employed(required)</b>	<b>Housing(required)</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Single <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Own
<b>Health Insurance(required)</b>	<b>Education Level(required)</b>		
<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private <input type="checkbox"/> No Insurance	<input type="checkbox"/> Grade 0 -8 <input type="checkbox"/> Grades 9 – 12/Non-Graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> GED/Equivalency	<input type="checkbox"/> 12 Grade + Some Post-Secondary <input type="checkbox"/> 2 or 4 years College Graduate <input type="checkbox"/> Graduate or other post-secondary <input type="checkbox"/> Unknown	

**Additional Household Members**

<b>(1) First name(required)</b>		<b>Last name(required)</b>			
<b>Gender(required)</b> <input type="checkbox"/> Female <input type="checkbox"/> Trans Female (MTF) <input type="checkbox"/> Male <input type="checkbox"/> Trans Male (FTM)		<b>Date of Birth(required)</b>		<b>SSN(required)</b>	
<b>Relationship to HOH(required)</b> <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild <input type="checkbox"/> Guardian <input type="checkbox"/> Foster child <input type="checkbox"/> Other Relative _____					
<b>Race(required)</b> <input type="checkbox"/> Black, African American <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Other _____		<b>Primary Language(required)</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Other _____		<b>Citizen(required)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Ethnicity(required)</b> <input type="checkbox"/> Hispanic, Latino or Spanish Origins <input type="checkbox"/> Not Hispanic, Latino or Spanish Origins				<b>Veteran(required)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Disability(required)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Marital Status(required)</b> <input type="checkbox"/> Single <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced		<b>Employed(required)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
				<b>Housing(required)</b> <input type="checkbox"/> Rent <input type="checkbox"/> Own	
<b>Health Insurance(required)</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private <input type="checkbox"/> No Insurance		<b>Education Level(required)</b> <input type="checkbox"/> Grade 0 -8 <input type="checkbox"/> 12 Grade + Some Post-Secondary <input type="checkbox"/> Grades 9 – 12/Non-Graduate <input type="checkbox"/> 2 or 4 years College Graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> Graduate or other post-secondary <input type="checkbox"/> GED/Equivalency <input type="checkbox"/> Unknown			
<b>(2) First name(required)</b>		<b>Last name(required)</b>			
<b>Gender(required)</b> <input type="checkbox"/> Female <input type="checkbox"/> Trans Female (MTF) <input type="checkbox"/> Male <input type="checkbox"/> Trans Male (FTM)		<b>Date of Birth(required)</b>		<b>SSN(required)</b>	
<b>Relationship to HOH(required)</b> <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild <input type="checkbox"/> Guardian <input type="checkbox"/> Foster child <input type="checkbox"/> Other Relative _____					
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<b>Ethnicity(required)</b> <input type="checkbox"/> Hispanic, Latino or Spanish Origins <input type="checkbox"/> Not Hispanic, Latino or Spanish Origins				<b>Veteran(required)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Disability(required)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Marital Status(required)</b> <input type="checkbox"/> Single <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced		<b>Employed(required)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
				<b>Housing(required)</b> <input type="checkbox"/> Rent <input type="checkbox"/> Own	
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**Additional Household Members**

<b>(3) First name(required)</b>		<b>Last name(required)</b>			
<b>Gender(required)</b> <input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Trans Female (MTF) <input type="checkbox"/> Trans Male (FTM)		<b>Date of Birth(required)</b>	<b>SSN(required)</b>
<b>Relationship to HOH(required)</b> <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild <input type="checkbox"/> Guardian <input type="checkbox"/> Foster child <input type="checkbox"/> Other Relative _____					
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<b>Disability(required)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Marital Status(required)</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		<input type="checkbox"/> Widow/Widower <input type="checkbox"/> Never Married	<b>Employed(required)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Housing(required)</b> <input type="checkbox"/> Rent <input type="checkbox"/> Own
<b>Health Insurance(required)</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private <input type="checkbox"/> No Insurance		<b>Education Level(required)</b> <input type="checkbox"/> Grade 0 -8 <input type="checkbox"/> Grades 9 – 12/Non-Graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> GED/Equivalency			
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<b>(4) First name(required)</b>			<b>Last name(required)</b>		
<b>Gender(required)</b> <input type="checkbox"/> Female <input type="checkbox"/> Male			<input type="checkbox"/> Trans Female (MTF) <input type="checkbox"/> Trans Male (FTM)		<b>Date of Birth(required)</b>
<b>Relationship to HOH(required)</b> <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild <input type="checkbox"/> Guardian <input type="checkbox"/> Foster child <input type="checkbox"/> Other Relative _____					
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<b>Disability(required)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Marital Status(required)</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		<input type="checkbox"/> Widow/Widower <input type="checkbox"/> Never Married	<b>Employed(required)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Housing(required)</b> <input type="checkbox"/> Rent <input type="checkbox"/> Own
<b>Health Insurance(required)</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private <input type="checkbox"/> No Insurance		<b>Education Level(required)</b> <input type="checkbox"/> Grade 0 -8 <input type="checkbox"/> Grades 9 – 12/Non-Graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> GED/Equivalency			
				<input type="checkbox"/> 12 Grade + Some Post-Secondary <input type="checkbox"/> 2 or 4 years College Graduate <input type="checkbox"/> Graduate or other post-secondary <input type="checkbox"/> Unknown	

**HOUSEHOLD INCOME:**

HOUSEHOLD TOTAL INCOME (Below list income information for applicant and all household members). Use additional paper if more space is needed

Name	Relationship to Applicant	Source of Income		FT / PT Employment	Gross Monthly Income
		Employment ● SS/SSI/VA ● Child Support Unemployment ● Pension ● Other			

**SOURCES OF INCOME:**

**NOTE: YOU MUST ATTACH INCOME DOCUMENTATION FOR EVERY PERSON IN HOUSEHOLD**

**CSBG STATEMENT OF NEED:** Please tell us why you need assistance on the line below: (please print)

Please tell us how you plan to address your situation going forward, what are your goals?

**Landlord/ Lender Information**

**Landlord or Lender Name:**

**Contact Telephone Number:**

**Landlord/Lenders Address:**

**Monthly Rental or Mortgage Amount:**

**Loan Number(If Applicable):**

**Contact Email Address:**

**Applicant Assurance Statement:**

- I have furnished true and correct information regarding household income and agree to promptly report changes in the household income or number of individuals living at the listed address.
- I grant the Agency and the Office of Social Services full permission to verify any and all information on this application both public and private sources and any entity which may have furnished me services.
- I understand that if knowingly give incomplete, inaccurate, or incorrect information, I am subject to criminal prosecution under Title 18 of the U.S. code.

**Verification of Information/Privacy Release**

My signature confirms the accuracy of the above information. I understand that the City of Baton Rouge/East Baton Rouge Parish, Division of Human Development & Services, Office of Social Services is a City Parish Agency and I give my consent for this agency to verify my information as well as release information to other City/Parish, State, as well as Federal agencies for the purpose of providing services.

**Primary Applicant Signature**

**Family Service Worker**

**Date (Valid for 30 days)**

**Date**



## Monthly Expense Form

**Attach/submit proof of all household expenses**

Housing	Monthly Payment		Flexible Expense	Monthly Payment
Mortgage or rent			Medical Expenses	
Phone			Prescription	
Electricity			Clothing	
Natural Gas			School Expenses	
Water and sewer			Child Care	
Cable			Food Expense	
Internet			Credit Card #1	
Home repairs			Credit Card #2	
Supplies			Other_____	
Other_____			Other_____	
Transportation	Monthly Payment		Insurance	Monthly Payment
Vehicle payment			Home	
Bus/taxi/ride sharing			Health	
Vehicle Insurance			Life	
Vehicle Repair			Burial Insurance	
Fuel Expense			Other_____	
Other_____			Other_____	
Other_____				
<b>Total</b>			<b>Total</b>	

**Total Expense** \_\_\_\_\_

# CERTIFICATION FORM

For  
Community Services Block Grant  
Program Participants

## ACKNOWLEDGING RECEIPT OF NOTICE ABOUT WHERE TO OBTAIN INFORMATION ON CSBG DISCRIMINATION COMPLAINT AND GRIEVANCE PROCEDURES.

I certify that I have been advised of my rights under Department of Health and Human Services' Regulations at 45 CFR 80, Title VI of the Civil Rights Act of 1964, and 45 CFR 84, Nondiscrimination on basis of handicap in Programs and Activities Receiving Federal Financial Assistance and understand these rights as they have been explained to me. Additionally, I have been provided a copy of the notice that includes information on where to file a CSBG discrimination complaint and/or grievance procedure.

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\_\_\_\_\_  
*PROGRAM(S) (CSBG FUNDED INDIRECTLY OR DIRECTLY)*

\_\_\_\_\_  
Program Participant Name (Print)

\_\_\_\_\_  
Program Participant Signature

\_\_\_\_\_  
Date

*“Equal Opportunity Employer/Program”  
“Auxiliary Aids and Services are available upon request to individuals with disabilities”*