WYCSP | Wyoming Community Services Program

Wyoming Department of Health
Public Health Division
Community Services Program

COVID-19 Affidavit of Eligibility

Name		Date of Assistance	

Individual		Family	
Gender:		**Household Type:**	
Age:		**Household Size:**	
Education Level:		**# of Household Members 18+:**	
Disconnected Youth:		**Housing:**	
Health:		**Level of Household Income:**	
Ethnicity/Race:		**Sources of Household Income:**	
Military Status:		**Other Income Source:**	
Work Status:		**Non-Cash Benefits:**	

By signing this statement, I am certifying that I am applying for assistance from a Community Services Block Grant (CSBG) funded agency and have no documented proof of income and I am eligible to receive services, as my household is at or below 200% of the Federal Poverty Level, due to the impacts of COVID-19. I further certify that the documentation provided and the facts contained in this application are accurate and true to the best of my knowledge and understand that falsified statements on this application or in the documentation provided could result in being denied CSBG-funded assistance in Wyoming.

_____ _____
Applicant Signature Date

_____ _____
Staff Signature Date