



County of Bucks Community Development Block Grant (CDBG)  
Self-Certification of Annual Income by Beneficiary

CDBG Project No: \_\_\_\_\_

**Instructions**

This data is collected for purposes of assessing the results of the Community Development Block Grant Program in benefitting recipients categorized according to income, race, and ethnicity. The information contained in this form will only be available to government officials responsible for monitoring the CDBG Program.

This is a written statement from the beneficiary documenting the Annual (Gross) Income, the number of beneficiary members in the family or household, and the relevant characteristics of each member for the purposes of income determination. For the purposes of this regulation, income will be defined according to the HUD regulations identified in the Code of Federal Regulations at 24 CFR, Part 5. *The information provided on this form is subject to verification by HUD at any time, and Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony and assistance can be terminated for knowingly and willingly making a false or fraudulent statement to a department of the United States Government.*

*All adult beneficiary members must sign this statement to certify that the information is complete and accurate, and source documentation will be provided upon request.*

**Contact Information**

Street Address: \_\_\_\_\_

City, State, Zip code: \_\_\_\_\_

**Please select the box(es) that apply to you**

I am of a single race:

- ☐ White  
☐ Black or African-American  
☐ Asian  
☐ American Indian or Alaskan Native  
☐ Native Hawaiian or Other Pacific Islander  
☐ Other

I am Multi-racial:

- ☐ American Indian or Alaskan Native and White  
☐ Asian and White  
☐ Black or African-American and White  
☐ American Indian or Alaskan Native and Black or African-American  
☐ Other multi-racial

- Are you Hispanic? ☐ Yes ☐ No  
Do you reside in Bucks County? ☐ Yes ☐ No  
Are you a veteran? ☐ Yes ☐ No

Do you or any members of your household have a long-term disability? ☐ Yes ☐ No

**Beneficiary Information (enter zero if not applicable)**

Total number of Persons living in household: \_\_\_\_\_

Number of minors under age 18 living in household: \_\_\_\_\_

Number of fulltime student(s) age 18 or older living in household: \_\_\_\_\_

Number of persons age 62 or older living in household: \_\_\_\_\_

**Income Information**

Annual gross income (total of all adult members) = \$ \_\_\_\_\_

Check all that apply to your household:

- ☐ Food Stamps \$ \_\_\_\_\_ ☐ Veteran's Administration (VA) medical services  
☐ TANF child care services ☐ Medicare  
☐ Special supplemental nutrition program-WIC ☐ Other TANF-funded services  
☐ TANF transportation services ☐ Medicaid-medical assistance  
☐ Housing Choice Voucher (Section 8), public housing  
☐ Other non-cash benefits or rental assistance \_\_\_\_\_



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CDBG Project No:

**Impacts of COVID-19:**

The information contained in in this form will only be available to government officials responsible for monitoring the Program. This is a written statement from the beneficiary. Please check all the boxes that currently apply to you and your household:

- ☐ I was laid-off from my primary place of employment as a result of COVID-19.
- ☐ I had a reduction in income as a direct result of COVID-19.
- ☐ I or a member of my household has been diagnosed with COVID-19 or are experiencing symptoms of COVID-19 and seeking a medical diagnosis.
- ☐ I am providing care for a family member or a member of my household who has been diagnosed with COVID-19.
- ☐ A child or other person in my household for which I have primary caregiving responsibility is unable to attend school or another facility that is closed as a direct result of COVID-19 public health emergency and such school or facility care is required for me to work.
- ☐ I am unable to reach my place of employment (or commence employment) because of imposed quarantine or self-quarantine (at direction of health care provider) as a direct result of the COVID-19 public health emergency.
- ☐ I have become the primary income earner or major support for a household as a direct result of COVID-19.
- ☐ I had to quit my job as a direct result of COVID-19.
- ☐ My place of employment is closed as a direct result of COVID-19.
- ☐ My unemployment status has been extended due to the quarantine imposed by the COVID-19 pandemic.
- ☐ My unemployment status has been extended due to the economic downturn and lack of available jobs as a direct result of the COVID-19 pandemic.
- ☐ My work or life situation has been affected by the COVID-19 pandemic, causing an inability to obtain employment.
- ☐ Without assistance, I will become homeless.
- ☐ Other [explanation must show clear reason how COVID impacted household]:

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**Certification**

I/we certify that this information is complete and accurate. I/we agree to provide, upon request, documentation on all income sources to HUD, County of Bucks, and/or the Program Administrator.

<b><u>Head of Household</u></b>		
Signature	Printed Name	Date
<b><u>Other Beneficiary Adults</u></b>		
Signature	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date