CARES Act 2020 to 2022

Community Services Block Grant

September 2020 through September 2022

Lincoln and Sublette County, Wyoming

About the Grant and Application Process

The purpose of the CARES Act (Corona Virus Aid, Relief and Economic Act) grant is to provide supplemental funds to enhance the quality of life for those individuals and families impacted by the COVID-19 pandemic in Lincoln and Sublette Counties. The funds are a means for those impacted to transition to self-sufficiency, or in the case of an elderly person, to remain in an independent living situation.

The grant objectives are to increase self-sufficiency by assisting clients to obtain a living wage; providing quality of life funds that solve a specific problem; and providing comprehensive case management to ensure clients are informed of available resources and to document progress towards self-sufficiency.

CARES Act grant funds are specified for:

- **Health Care Services** – emergency medical, dental, prescription and vision related costs
- **Rent** – emergency assistance to prevent eviction, moving and homelessness; to create stable housing; to enable the individual to gain employment
- **Minor Home Repair** – emergency assistance to improve safety and health - sanitary conditions

Application Process - The primary qualification to apply for grant services is that income must be documented and cannot exceed 200% of the federal poverty level.

1. Obtain an application from High Country Behavioral Health in Afton or Pinedale or from a local provider.
2. **Complete the full application following all instructions.** Make sure to fill in each area on the application as an incomplete application will delay a decision.
3. Mail or bring the completed application to a High Country Behavioral Health office:
   Lincoln County: P.O. Box 376, Afton, Wyoming 83110
   Telephone: 307-885-9883 Lincoln County street address: 389 Adams Street
   Sublette County: P.O. Box 856 Pinedale, Wyoming 82941
   Telephone: 307-367-2111 Sublette County street address: 24 Country Club Lane

   Questions? Call HCBH CARES Act Coordinator at 307-885-9883 x 114.

WYCSP | Wyoming Community Services Program

CARES Act 2020-2022 Block Grant (CSBG) Application
Lincoln County and Sublette County, Wyoming

Please SEND A COPY of the following required documentation:

1. Applicant – Driver's License or Government Issued Picture ID Card and Social Security Card
2. Other Family Members – Provide full names, birthdates and their Social Security Card(s)
3. Proof of Income – Total Monthly Income for all household members 18 years or older for the 30 days preceding and including the application date. If an applicant has zero income, a self-declaration statement is required.

Applicant Name:				Date:	
Physical Address:		City		State of Residence	
Mailing Address with ZIP code:		Telephone:		Tribal Affiliation	
Date of Birth:	Age:	Gender: ❑Female ❑Male	Last 4 digits of SSN:	Household Size:	# of Children under 18
Applicant Ethnicity: ❑Non-Hispanic/Non-Latino ❑Hispanic/Latino	Applicant Race: ❑American Indian or Alaskan Native ❑Asian ❑Black/African American ❑White ❑Native Hawaiian/Pacific Islander ❑Other ❑Multi-Race (any 2 or more of the races listed)				Veteran: ❑Yes ❑No
What is the highest level of schooling completed? A=Applicant O=Other ____0-8th Grade____9-12th Grade____High school Graduate or GED ____Some college, no degree____Associate degree____Bachelor's Degree			Do you or any family members have health insurance? ❑ Yes ❑ No (If yes, what Type) A=Applicant O=Other ____Private____VA____Medicaid____Medicare ____Disability____Other: (please list) _____		
Is anyone disabled? ❑Yes_____❑No A=Applicant O=Other	Household Type: ❑ Single Person ❑Single Parent Female ❑Single Parent Male ❑Two Adults ❑Two Adults and Children ❑ Other (Please explain) _____			Type of Housing: ❑Own ❑Rent ❑Other	

Please list all family members.

Full Name	Date of Birth	Last 4 digits of SSN

What is the family's source of income? (Check all that apply) ❑Employment ❑Social Security ❑Disability ❑Unemployment Insurance ❑Pension ❑ Other:_____	Total Household Income for the last 30 days. $_____ If income is zero, applicant must complete self-declaration.

Date	Specific Request for Assistance	Amount	
	Total Amount Requested =		

I 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 CARES Act -CSBG-funded assistance in Wyoming.

SIGNATURE:_____ DATE: _____

Self-Declaration for zero income or missing required documentation

Only complete if you have no source of income or are missing any of the required documentation.

Please check all that apply:

____ The Household has **no source** of Income.

I,_____, do hereby declare under penalty of perjury that I have received no income from any source during the past 30 days and that I have been unemployed during that time. I maintain basic necessities by:

_____

____ No Proof of Identification

____ No Social Security Card for ALL Household Members

____ No Proof of Residency

_____

I,_____, do hereby declare under penalty of perjury that I do not have copies of the required CSBG documentation. I cannot provide all required documentation because:

_____

_____

Applicant (Printed Name) Signature Date

_____

CARES Act - CSBG Staff Printed Name Signature Date

FY 2020-2022 Lincoln and Sublette County, Wyoming
CARES Act Community Services Block Grant
Consent for Use and/or Disclosure of Protected Health Information

1. AUTHORIZATION: I hereby authorize the use or disclosure of protected health information about me as described below. I understand that the information to be released and/or requested does not pertain to the exceptions to confidentiality as outlined in 42 CFR Federal confidentiality regulations

Client: _____
(Last Name) (First Name) (Middle Name) (Maiden Name)

Date of Birth: _____ Client ID #: _____

Address: _____

Authorize: [ ] High Country Behavioral Health Staff or [ ] Other _____

To exchange information with: CSBG related services

(Specific description of person(s) and/or Organization)

2. INFORMATION TO BE USED OR DISCLOSED: (Place a check mark [_] next to the information to be used or disclosed, then have client initial.)

[ ] Diagnosis	[ ] Psychiatric Evaluation	[ ] Medication(s)
[ ] Results of Psychiatric Testing	[ ] Assessment Information	[ ] Communicable Disease Information
[ ] Treatment Planning Information	[ ] Reason for Termination	[ ] Progress Notes
[ ] Number of un/kept appointments	[ ] Recommendations	[ ] Other: _____

3. PURPOSE OR NEED FOR USE OR DISCLOSURE: (Place a check mark [_] next to the reason for use or disclosure, then have client initial.)

[ ] Collaboration with School [ ] To comply with Court Order
[ ] For client treatment [X] Other: CSBG related service funding

4. [ ] This information may be shared by fax, e-mail, telephone or documents sent by mail.

5. This authorization will expire as noted below: (Place a check mark [_] next to the duration, then have client initial.)

[ ] At the end of 60 days
[ ] At termination of my treatment or at the end of 1 year, whichever is first
[X] At the happening of the following event or date (less than 1 year from date signed): September 2022

6. I understand that I may revoke this authorization by completing Part 9 below. However, I understand that if I revoke this authorization, it will not have any affect on actions already taken by High Country Behavioral Health in reliance on this authorization.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

8. I understand that my records are protected by federal and state laws and cannot be disclosed without my written permission, except as noted in High Country Behavioral Health's Notice of Privacy Practices. I UNDERSTAND THAT THIS RELEASE ALSO INCLUDES ANY REFERENCE TO DRUG AND OR ALCOHOL TREATMENT AS PROTECTED BY FEDERAL LAW.

_____ _____
(Signature of Client or Representative) (Date of Signature) (Witness Signature) (Date of Signature)

_____ _____
(Printed Name of Client or Representative) (Description of Representative's Authority to Act for Client, i.e. Relationship)

9. REVOCATION: I wish to revoke this authorization: _____ Date: _____
(Signature of Client or Representative)

Person witnessing revocation: _____ Date: _____

NOTE: The receiving individual or organization understands that it IS NOT TO RE-RELEASE any of the confidential information received. Once the information is used and/or disclosed by HCBH, it is no longer protected by the federal privacy regulations and may be subject to re-disclosure by the recipient.