

SDGE Community Assistance Fund (CAF) 2023 / 2024

APPLICATION INFORMATION

Phone: (760)742-8600 x 164 | Email: CAF2023@sctca.net

INFORMATION

The CAF (Community Assistance Fund) Grant is made possible by SDGE through SCTCA. To be eligible for the grant in the amount of \$599, you must be income qualified and meet the residence guideline. Please make note that your monthly income must not exceed 200% of the Federal poverty income.

REQUIREMENTS

Recognized by one of the following Tribes:

Agua Caliente	Barona	Cahuilla	Campo	Chemehuevi
Ewiiaapaayp	lipay Nation of Santa Ysabel	Inaja Cosmit	Jamul	La Jolla
La Posta	Los Coyotes	Manzanita	Mesa Grande	Pala
Morongo	Pauma	Rincon	San Manuel	San Pasqual
Santa Rosa	Soboba	Sycuan	Torres Martinez	Viejas

AND

Must be age 18 or older

AND

- Reside within San Diego County OR
- Reside within South Orange County with the following zip codes:

	<u> </u>	<u> </u>		
92624	92629	92637	92651	92653
92656	92672	92673	92675	92677
92679	92688	92691	92692	

REQUIRED DOCUMENTATION FROM APPLICANT

- Provide valid identification and a social security card for applicant and all household members •
- Provide Indian Certification Form or Tribal Member Identification/Affiliation
- Provide monthly income such as, but not limited to: paycheck, unemployment, disability check, etc.
- Complete a CAF 2023 / 2024 Application
- MANDATORY Identification Verification will be made through In-Person Applicants, FaceTime, or Zoom

ACKNOWLEDGMENT

By signing this form, you are acknowledging there is an income guideline and you, the applicant, must submit all and any documentation requested from CAF (Community Assistance Fund) to verify eligibility for this program.

Applicant Signature: _____ Date: _____





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HEAD OF HOUSEHOLD INFORMATION						
Name of Applicant:						
Physical Address: C	ty:	State:	Zip Code:			
Mailing Address: (If differs from above address) Ci	ty:	State:	Zip Code:			
Is your place of residency located on an Indian Res If yes, please specify which reservation:	Yes	/ No				
Phone Number:	Alternate Number:					
Email Address:						

FAMILY COMPOSITION

Please list your immediate household members, including minor dependents, living in your home.

(For each member you list, you are certifying that each member is living in your household)
PLEASE PROVIDE A COPY OF DOCUMENTS FROM COLUMN F (FOR APPLICANT) AND COLUMN H (FOR ALL HOUSEHOLD MEMBERS)

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Α	В	с	D	E	F	G	н
Name (Include Applicant)	Relationship to Applicant	D.O.B	Age	Gender (M/F)	Specify Enrollment/Descendent & Reservation	Highest Education/Grade Level	Social Security #
	SELF						

HOUSEHOLD INCOME

Include all earned/unearned income for all adult household members. For each source of income, please **ATTACH** income verification for the <u>current month</u>.

Name of Person Receiving Income	Source of Income	Monthly Amount

EMERGENCY NEEDS ASSESSMENT

What is your immediate need? Please explain in detail:

How has your immediate need impacted your household resulting in a crisis/episode of need? Please explain in detail (attach statement if additional space is needed):

APPLICATION CERTIFICATION AND OTHER INFORMATION

Is anyone listed in the Family Composition fleeing to avoid pers	secution or c	ustody o	f confinem	ent after co	onvictio	n for a crime or
attempt to commit a crime (which is a felony) under a federal of	or state law?	(Circle O	ne) Y	es	/	No
			-			
If yes, please specify who:						
Have you or any household members applied for and received	funding from	n TANF, F	PEAF and/o	r CAF in the	e past w	ith SCTCA,
State (or County), Federal, or Tribal program? (Circle One)	Yes	/	No			

Program Name: ______ Date Funds Received: ______





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I (We) certify under perjury that:

- 1. My (our) request for CAF is to assist my household to deal with a specific crisis or episode of need that resulted from the immediate need.
- 2. I (we) have exhausted all other resources available to me for this type of assistance.
- 3. I will not receive, nor do I expect to receive, additional monies for duplicate services from any other organization or program.
- 4. All of the information provided on my CAF 2023 / 2024 Application is true and correct.
- 5. I (we) understand that falsification of any information is grounds for termination from the CAF 2023 / 2024 program and may result in SCTCA's recovery of any monies paid to me while in the program.

<u>.</u>		
Signature	(Head of Household)) Date

Signature (2nd Adult)

Date

• If awarded funding, I agree to completing a post-assistance survey within 3-5 months of receipt.

I understand that I may be contacted by email and/or by phone to take the survey.

Signature (Head of Household) Date

Office Use Only						
Office:		RCVD by	/ Staff Initials:		Date:	
Grant ID: 17 Total Countable Income:			Signature:			
(Circle One)	APPROVED	/	DENIED	Decision Date:		
If denied, reason:						