Mayor Hector C. Lora

330 PASSAIC STREET, PASSAIC, NEW JERSEY 07055
PHONE: (973) 365-5510 / FAX: (973) 472-0436

The Coronavirus Aid, Relief, and Economic Security (CARES) Act
Medical Technician Training/Phlebotomy Certification

This program provides assistance to City of Passaic residents following the current COVID-19 pandemic, allowing for payment assistance in order to obtain medical technician training and/or phlebotomy certification in order to prevent, prepare for or respond to Coronavirus.

In order to qualify for this program, each applicant must provide the following information:

☐ Signed and completed attached HUD *Self-Certification of Income*

☐ Number of people residing in the household

☐ Copies of at least three forms of documentation providing proof of residency (such as a PSE&G bill, cable bill, rent receipt, bank statement, driver's license, etc. - should all show the **same** address)

☐ Copies of last 3 paystubs

☐ Race and ethnicity

☐ Completed, signed application

You may email your completed application and all supporting backup to Judith Sanchez at jsanchez@cityofpassaicnj.gov. Applications can also be dropped off at City Hall by **APPOINTMENT ONLY**. For any questions or appointments, please contact Judith Sanchez at the email above, or by phone at 973-365-5512.

WARNING: 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. If upon review of this application we are made aware that the applicant has received duplicative services via other funding sources, the applicant will be required to repay the entire awarded amount of CDBG-CV funding back to HUD.

APPLICANT INFORMATION

Applicant's Name: _____

Applicant's Address: _____

Applicant's Email Address: _____

Applicant's Phone Number: _____

Applicant's Social Security Number: _____

Applicant's Date of Birth: _____

RACE AND ETHNICITY

*For reporting purposes only; do not leave this section blank. Note that Hispanic is not a race, but an ethnicity. Please choose one of the following from the RACE category:

SINGLE RACE:

☐ White ☐ Black/African American ☐ American Indian/Alaskan Native

☐ Asian ☐ Pacific Islander ☐ Other: _____

MULTI-RACE:

☐ American Indian/Alaskan Native and White ☐ Asian and White

☐ American Indian/Alaskan Native and Black ☐ Black/African American and White

☐ Other: _____

ETHNICITY: Are you of Hispanic or Latino origin? ☐ Yes ☐ No

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EMPLOYMENT INFORMATION

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Supervisor's Name/Job Title: _____

Employer Phone Number: _____

Job Title: _____ Years at Job: _____

Annual Income: $ _____ Hourly Income: $ _____

Overtime Income (if Applicable): $ _____ per month

APPLICANT CERTIFICATION STATEMENT:

I certify that all information provided on this application is true, accurate and complete to the best of my knowledge and belief. If it is found that any submitted information is inaccurate, my application will be denied. I understand that my application will not be approved for the City of Passaic's CARES Act Medical Technician Training and Plebotomy Certification Program until all requested information has been forwarded to the Office of Community Development at 330 Passaic Street, Passaic, NJ and the Office of Community Development have deemed my application "income qualified" for participation under the rules and regulations governing the federal funding. I agree that if any information is found in any way to be incorrect/fraudulent after official approval of my application and the reimbursement of the program participation fee, I agree that I will repay in full all funds received as well as any penalties, fees or interests accrued thereon.

_____ _____

Signature of Applicant Date

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U.S. Department of Housing and Urban Development
Community Planning and Development
Community Development Block Grant (CDBG)

SELF CERTIFICATION OF ANNUAL INCOME BY HOUSEHOLD

INSTRUCTIONS: This is a written statement from the beneficiary documenting the definition to determine "Annual (Gross) Income", the number of household members in the family or household (as applicable based on the activity), and the relevant characteristics of each member for the purposes of income determination. To complete this statement, ensure that sources of income under the definition of income are included, fill in the blank fields below, and check only the boxes that apply to each member. Adult beneficiary members must then sign this statement to certify that the information is complete and accurate, and that source documentation will be provided upon request.

Definition of Income

All sources of income from every member of the household; including salaries and wages, social security, alimony, child support, welfare, investment income, unemployment benefits, stimulus income, other.

Household **Information**

First and Last Names:	**Social Security # or Driver's License #**	**HH**	**CH**	**DIS**	**62+**	**S≥18**	**<18**	**<15**
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								

HH = Head of Household; **CH** = Co-Head of Household; **DIS** = Person with disabilities; **62+** = Person 62 years of age or older; S≥18 = Fulltime student age 18 or over; <18 = Child under the age of 18 years; **<15** = Minor under the age of 15 years

Contact Information

Address Line 1:	City:	
Address Line 2:	State:	Zip Code:
Telephone #:	Email Address:	

Income Information

Annual gross income (total of all household members) = $ _____

COMPLETE SIGNATURES ON SECOND PAGE

U.S. Department of Housing and Urban Development
Community Planning and Development
Community Development Block Grant (CDBG)

SELF CERTIFICATION OF ANNUAL INCOME BY HOUSEHOLD

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

HEAD OF HOUSEHOLD		
Signature 1	**Printed Name**	**Date**

OTHER BENEFICIARY ADULTS*		
Signature 2	**Printed Name**	**Date**
Signature 3	**Printed Name**	**Date**
Signature 4	**Printed Name**	**Date**
Signature 5	**Printed Name**	**Date**
Signature 6	**Printed Name**	**Date**
Signature 7	**Printed Name**	**Date**
Signature 8	**Printed Name**	**Date**
Signature 9	**Printed Name**	**Date**
Signature 10	**Printed Name**	**Date**
Signature 11	**Printed Name**	**Date**
Signature 12	**Printed Name**	**Date**

* Attach another copy of this page if additional signature lines are required.

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