

Microenterprise Program SELF-CERTIFICATION of Income for

City of / Town of / County of _____ CDBG Funded Activity

Program Activity: Technical Assistance Support Services

Page 1 to be filled out by Participant

Part I: Confidential Participant / Beneficiary HUD Demographic Data

(This section is voluntary.)

Ethnicity (Select One)	<input type="checkbox"/> Not Hispanic	<input type="checkbox"/> Hispanic
Race	(Select One)	
White	<input type="checkbox"/>	
Black/African American	<input type="checkbox"/>	
Asian	<input type="checkbox"/>	
American Indian/Alaskan Native	<input type="checkbox"/>	
Nat. Hawaiian/Other Pacific Isl.	<input type="checkbox"/>	
Am. Indian/Alaskan Nat. & White	<input type="checkbox"/>	
Asian & White	<input type="checkbox"/>	
Black/African American & White	<input type="checkbox"/>	
Am. Indian/Alaskan & Black/African	<input type="checkbox"/>	
Other Multi-Racial	<input type="checkbox"/>	

Part II: Confidential Participant / Beneficiary Income Certification

(Must be completed and signed before microenterprise services are provided.)

1) Number of Employees & Owners:

The total number of employee(s) is: _____. The total number of Owner(s) is: _____. Combined Employee(s) and Owner(s) = _____.

2) Number of Family Members & Gross Income:

My total family size consists of _____ members, and the total gross annual income* for all adult members is \$_____.

*Gross annual income must include all sources of income (wages, child support, SSI, unemployment, pension, income from assets, etc., but does not include the income of live-in aids, per 24 CFR 5.403).

I certify that the information given on this form is true and accurate to the best of my knowledge. I am aware that there are penalties for willfully and knowingly giving false information on an application for Federal or State funds, which may include immediate repayment of all Federal or State funds received and/or prosecution under the law. I understand that the information on this form is subject to verification by state and federal personnel as part of compliance monitoring.

Participant / Beneficiary Signature: _____ Date: _____

Participant / Beneficiary Name (print): _____

Participant Physical Home Address: _____, City _____

Microenterprise Program SELF-CERTIFICATION Verification by

City of / Town of / County of _____ CDBG Funded Activity

Page 2 to be filled out by Program Operator

Microenterprise Program Information:

Name of Microenterprise Program Operator: _____

Source of CDBG funding: Grant #: _____ - Or - PI Waiver Fiscal Year: _____

Microenterprise Business Size (# of Employees & Owners) Verification:

- Business has: No employees, as the Participant does not have an operating business
 Five or fewer employee positions with owners
 More than five employee positions with owners **NOT ELIGIBLE for CDBG ASSISTANCE**

Microenterprise Participant/Beneficiary Income and Location Verification:

Effective Date of the Income Limit Chart being used: _____

- Family is: 30% or less (Extremely Low Income)
 31%-50% (Low Income)
 51%- 80% (Moderate Income)
 Over 80% of median income: **NOT ELIGIBLE for CDBG ASSISTANCE**

Program Operator must:

- 1) Print the current HCD Income limits from the HCD website (NOT HUD's); and
- 2) Circle the applicable family size and annual income on HCD limit printout and place in participant file.
- 3) Must complete confidential demographic data, if participant/beneficiary leaves blank.

Participant / Beneficiary Name: _____

Participant / Beneficiary Physical Home Address: _____ In Jurisdiction Limits

Business Physical Address: _____ In Jurisdiction Limits

NOTE: Physical location of business must be in Jurisdiction. If no business, then Participants / Beneficiary must live in Jurisdiction.

Program Operator Certification: *I certify that Participant / Beneficiary demographic data provided is true and correct, to the best of my knowledge. I certify that, using the current HCD annual income publication compared to stated family size and gross income, resulted in the income level indicated above. I certify that the information regarding microenterprise business size is correctly indicated above. I certify that the residency of the Participant / Beneficiary and business address is true and correct per the requirements of 24 CFR 570.486(b) and/or (c) as applicable.*

Note: This completed certification whether Participant / Beneficiary receives microenterprise TA or Support Services or not, must be maintained in the Confidential Program file for review at time of monitoring.

Program Operator Name (printed)

Job Title

Signature:

Date:

Eligibility is valid until (three years after certification signed) Date: _____