SHELBY COUNTY COMMUNITY SERVICES AGENCY
MEDICAL PRESCRIPTION PROGRAM

REQUIRED DOCUMENTATION

☐ SOCIAL SECURITY CARDS FOR EACH HOUSEHOLD MEMBER
☐ VALID GOVERNMENT ISSUED IDENTIFICATION
☐ PROOF OF ALL HOUSEHOLD INCOME FOR THE LAST 30 DAYS FOR ALL MEMBERS OVER THE AGE OF 18
☐ MEDICAL PRESCRIPTION SCRIPTS/ PHARMACY PRINTOUT

REQUIRED DOCUMENTATION OF INCOME

SOCIAL SECURITY, SSI, PENSION, DISABILITY AND VA BENEFITS
☐ CURRENT AWARD LETTER
☐ CURRENT PRINTOUT FROM SOCIAL SECURITY ADMINISTRATION OFFICE

TANF/AFDC INCOME
☐ CURRENT DISPOSITION PRINTOUT FROM DEPARTMENT OF HUMAN SERVICES
☐ CURRENT LETTER STATING ELIGIBILITY RECEIVED BY MAIL. THE LETTER SHOULD INCLUDE BENEFIT AMOUNT.

CHILD SUPPORT
☐ CURRENT PRINTOUT FROM JUVENILE COURT WITH THE GROSS AMOUNT COLLECTED MONTHLY
☐ CURRENT OUT OF STATE CHILD SUPPORT – LEGAL COURT DOCUMENT WITH STATE SEAL

TANF/AFDC INCOME
☐ CURRENT DISPOSITION PRINTOUT FROM DEPARTMENT OF HUMAN SERVICES
☐ CURRENT LETTER STATING ELIGIBILITY RECEIVED BY MAIL. THE LETTER SHOULD INCLUDE BENEFIT AMOUNT.

UNEMPLOYMENT BENEFITS
☐ CURRENT PRINTOUT FROM STATE OF TENNESSEE (CLAIM SUMMARY), INCLUDING STATES OUTSIDE OF TENNESSEE

EMPLOYMENT
☐ CHECK STUBS FROM EMPLOYER — IN ORDER BY DATE RECEIVED
  ➢ LAST 30 DAYS OF PAY
☐ CURRENT LETTER VERIFYING GROSS WAGES (PAY RATE, HOURS WORKED PER WEEK, PAY DATE)
  ➢ MUST BE SIGNED AND DATED
  ➢ MUST BE ON 8 ½ x 11 COMPANY LETTERHEAD

ZERO INCOME
☐ COMPLETE SELF-DECLARATION OF ZERO INCOME FORM—ALL MEMBERS 18 YEARS OF AGE AND OLDER (PROVIDED UPON REQUEST)
☐ WRITTEN STATEMENT VERIFYING ZERO INCOME FROM FRIEND OR FAMILY MEMBER THAT IS NOT LIVING IN THE HOME AND HAS NOT APPLIED FOR LIHEAP.

SELF EMPLOYED
☐ CURRENT/PRIOR YEAR TAX RETURN
☐ SELF-EMPLOYMENT FORM (PROVIDED UPON REQUEST)

Revised: 3/20/20

Email completed applications to CSBG@ShelbyCountyTN.gov or mail application to 2670 Union Extd Suite 500 Memphis, TN 38112
SHELBY COUNTY COMMUNITY SERVICES AGENCY
MEDICAL PRESCRIPTION PROGRAM
2670 UNION AVENUE EXTD, 5th FLOOR
MEMPHIS, TN 38112
(P) 901-222-4200 (F) 901-222-4242

CLIENT’S NAMES: ________________________________________________________________________________
CLIENT’S DOB: _____/_____/_______ SOCIAL SECURITY# _____________________________
CLIENT’S ADDRESS: _____________________________________________________________________________ APT# ______________
CITY __________________________ STATE __________ ZIP CODE _______
PHONE# _________________________ CELL PHONE# ____________________________

PHYSICIAN’S NAMES: _____________________________________________________________________

CHOSE YOUR PREFERRED PHARMACY:

- MADISON PHARMACY
  1350 CONCOURSE AVE, #111
  MEMPHIS, TN 38104
  901-321-5530

- THE MEDICINE SHOPPE
  4770 KNIGHT ARNOLD RD
  MEMPHIS, TN 38118
  901-363-075

COMMENTS: _______________________________________________________________________________
________________________________________________________________________________________

Customer Signature: _____________________________________________________ _____/_____/_____

To Be Completed By Office Only:

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>QUANTITY</th>
<th>STRENGTH</th>
<th>RX NUMBER</th>
<th>PRICE</th>
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GRAND TOTAL $_____

PRARMACIST/PHARM TECH’S SIGNATURE ___________________________ _____/_____/_____

SIGNATURE DATE TIME

CSA Staff Signature: ___________________________ _____/_____/_____

SIGNATURE DATE

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# APPLICATION FOR CSBG SERVICES

**Community Services Block Grant**

**SERVICE APPLYING FOR:**
- [ ] NUTRITION
- [ ] HEALTH
- [ ] EMERGENCY SERVICES
- [x] OTHER
- [ ] EMPLOYMENT
- [ ] EDUCATION
- [ ] INCOME MANAGEMENT
- [ ] HOUSING

---

**For Agency Office: Use Only**

- DATE APPLICATION RECEIVED: 
- DATE APPLICATION COMPLETED: 
- APPLICATION STATUS: APPROVED  DENIED

---

## Applicant Information

- **Applicant Name (first & last):**
- **Telephone:**
- **Cell:**
- **Current Address:**
- **City:** Memphis
- **State:** TN
- **Zip:**
- **County:** Shelby
- **Email:**
- **Mailing Address (if different from Current Address):**
- **City:**
- **State:**
- **Zip:**

---

**LIST ALL HOUSEHOLD MEMBERS (INCLUDING APPLICANT):** Begin with applicant, then spouse, then oldest child, etc.). Use additional paper if you need more space.

<table>
<thead>
<tr>
<th>NAME (must provide first and last name)</th>
<th>MARITAL STATUS</th>
<th>SOCIAL SECURITY NUMBER</th>
<th>DATE OF BIRTH</th>
<th>AGE</th>
<th>SEX</th>
<th>VETERAN</th>
<th>RACE (Optional to Provide)</th>
<th>EDUCATION</th>
<th>HOUSEHOLD MEMBER</th>
<th>RECEIVES FOOD STAMPS, SUPPLEMENTAL SECURITY INCOME, FAMILIES FIRST CASH ASSISTANCE (INDICATE ANY RECEIVING)</th>
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<tbody>
<tr>
<td>Household Member: Self</td>
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<td>White, Black, Hispanic, Asian/Pacific Islander, Native American, Native Hawaiian, Other - define</td>
<td>Y or N</td>
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<td>Household Member:</td>
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## Housing

- [ ] OWN  
- [ ] RENT  
- [ ] SECTION 8  
- [ ] PUBLIC HOUSING AUTHORITY  
- [ ] HOMELESS  
- [ ] HUD

- [ ] CHILD CARE: Do you have child care? Y or N Is it reliable? Y or N
  - [ ] I don't have any children.
  - [ ] I pay for childcare: $ / week. Type of care:  
  - [ ] I have subsidized childcare.
  - [ ] A friend or family member provides childcare.
  - [ ] My child / children participate in Head Start/Early Head Start. Which location?
  - [ ] My child/children are in school with appropriate after school care.
  - [ ] My child/children are in school without appropriate after school care.
  - [ ] I do not have affordable child care options. Other: 

- [ ] HEALTH: Do you have health insurance? Y or N
  - [ ] I have medical insurance provided by my employer.
  - [ ] My household members have medical insurance provided by my employer.
  - [ ] I am provided sick leave benefits.
  - [ ] I have a retirement plan.
  - [ ] My household members have TennCare, Medicaid, Medicare, or some other medical insurance provided by the government.
  - [ ] I do not have medical insurance.
  - [ ] My household members do not have medical insurance.
  - [ ] I have supplemental prescription assistance to help pay for medications.
  - [ ] I have copay for my medications.
  - [ ] I do not have supplemental medical insurance to help pay for medications.
  - [ ] I (or any household members) often go without my medications due to lack of money. Other: 
  - [ ] I have a medical condition that affects my ability to contribute to my household. If so, please explain:

## NUTRITION

- [ ] NUTRITION: Do your family experience food insecurity for 1 or more times throughout the month? Y or N Is satisfied through food banks / commodities? Y or N

## SUPPORTS

- [ ] SUPPORTS: Do you have other family, community, or agency supports? Y or N If yes, please explain

## TRANSPORTATION

- [ ] TRANSPORTATION: Do you have transportation? Y or N Is it reliable? Y or N

## EMERGENCY NEEDS

- [ ] EMERGENCY NEEDS: I am currently in need of the following emergency assistance:
**HOUSEHOLD TOTAL INCOME** (Below list income information for applicant and all household members). Use additional paper if more space is needed.

<table>
<thead>
<tr>
<th>NAME</th>
<th>SOURCE OF INCOME</th>
<th>FT / PT</th>
<th>HIRE DATE</th>
<th>GROSS MONTHLY INCOME</th>
<th>IF EMPLOYED, PROVIDE EMPLOYER’S NAME &amp; ADDRESS</th>
<th>Is the income reliable?</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>☐ Employment ☐ SS / SSI ☐ VA ☐ TANF ☐ Child Support ☐ Unemployment ☐ Other</td>
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</table>

**SOURCE OF INCOME:**

► NOTE: YOU MUST ATTACH INCOME DOCUMENTATION FOR EVERY PERSON IN HOUSEHOLD ◄

**CSBG STATEMENT OF NEED**

Please tell us why you need assistance on the lines below: (please print)

__________________________________________

Please tell us how you plan to address your situation going forward, what are your goals?

__________________________________________

Applicant Certification:

I certify that all of the information provided by me is true and correct. I authorize the verification of any and all information provided herein to determine my eligibility, and acknowledge I have been informed of the appeal process. I understand that I will be notified in writing of my eligibility status. Identifying information provided by you for determination of your eligibility for CSBG and for the provision of services from the program will be considered confidential, unless otherwise authorized or required by law, will not be shared with any other persons or agencies except for the purposes directly related to the administration of the CSBG program. I attest under penalty of perjury that all persons applying for or receiving aid are either a United States citizen or qualified alien as defined by 8 U.S.C § 1641(b), or eligible immigrants. I swear under penalty of perjury (a crime for lying under oath) and all other applicable penalties that the statements made on this application, any attachments, and to whoever interviewed me are true and correct. I understand that anyone who fraudulently covers up a material fact or who knowingly gives false information for the receipt of CSBG assistance is liable upon conviction of a fine of $10,000 or imprisonment for not more than five years, or both.

I DO OR DO NOT AGREE THAT THE INFORMATION CONTAINED IN MY APPLICATION MAY BE SHARED WITH OTHER AGENCIES FROM WHICH I SEEK ADDITIONAL SERVICES.

APPLICANT SIGNATURE: ____________________________ Date: __________

If Representative for Applicant, give relationship and reason for signing: ____________________________________________________________

NO PERSON ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, SEX, AGE, DISABILITY, ANCESTRY, STATUS AS A VETERAN, OR ANY OTHER CHARACTERISTICS PROTECTED BY FEDERAL, STATE, OR LOCAL WILL BE EXCLUDED FROM PARTICIPATION IN, OR BE DENIED BENEFITS OF, OR BE OTHERWISE SUBJECT TO DISCRIMINATION IN THE OPERATION OF THE CSBG PROGRAM.

To be completed by Agency Staff Only:

Number in Household: __________

Total Monthly Income: __________

Total Annual Income: __________

DATE/TIMETAKEN: __________

Eligibility:

Method of Eligibility: Verification or Self-Declaration

Customer Notification: Verbal or Written

National Goal: #1 __________ #6 __________

Goal Was: Achieved __________ Maintained __________ Not Achieved

Eligibility Period: / / to / /

Explain: __________________________________________________________

INTAKE WORKER SIGNATURE: ____________________________ DATE CERTIFIED: __________

SIGNATURE OF DETERMINING AGENCY OFFICIAL: ____________________________ DATE: __________
Release of Information

This is to confirm that I do hereby give permission to Shelby County Government Comprehensive Emergency Assistant Program to share and/or secure any information necessary to certify me for the CSBG Emergency Cash Assistance Program. I understand that this information will only be shared, secured, or verified professionally while protecting my rights to confidentiality. I also hereby grant the Agency permission to secure additional resources on my behalf, if necessary and appropriate. I do request, however, that _________________________________________________not be contacted.

Access to Client Records

I further acknowledge that I am aware that Program Supervisors and/or Managers, DHS Auditors, and State Comptroller Auditors will have access to my client records.

Reliability of Information

I also certify to the best of my knowledge that all information provided by me in this approval process is accurate and true. I am completely aware that anyone who knowingly covers up a material fact or gives false information for eligibility determination is liable for prosecution under applicable criminal law.

Grievance Procedures

As a client applying for assistance through Shelby County Government Community Services Agency, you have the right to appeal and request a fair hearing. You must contact the Agency for the proper complaint form. A complaint for must be filled out triplicates and completed within 30 days. After a decision has been made, you, the Agency and the State will retain a copy of the complaint form. The Administrator will contact the Department of Human Services for a final decision if you are not satisfied after a local hearing.

Follow Up Notification

I certify that I have been informed and understand that Shelby County Government Community Services Agency may conduct a follow-up assessment after my initial certification for CSBG services. I agree to provide all necessary requested information for assessment. I certify that I have provided names of two people who will know how to contact me during the next year.

Title VI Compliance

I certify that I have been informed of the Title VI Civil Rights Act of 1964 which states no person will be discriminated against based on age, race, sex, color, religion, or national origin under any program provided by Shelby County Government Community Services Agency.

Citizenship

I certify that at least one adult member of my household is a citizen of the United States of America.

Release of Medical Information (HIPAA-Health Insurance Portability and Accountability Act)

I___________________________________________, agree that my medical information may be disclosed to Shelby County Government Communities Agencies and affiliates and also shared with other service provider (s) any agreeing CSA partner agencies concerning assistance for this program.

Client Signature ___________________________ Date ______________________

Staff Signature ___________________________ Date ______________________

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