

# SDC APPLICATION

PLEASE COMPLETE THE FOLLOWING INFORMATION TO DETERMINE ELIGIBILITY FOR SDC PROGRAM(S).  
Please print using blue or black ink

## APPLICANT INFORMATION

|                   |                  |                      |
|-------------------|------------------|----------------------|
| Application Date: | Agency Location: | SSN: *** - ** - ____ |
| First Name:       | Last Name:       | Middle Name:         |
| Date of Birth:    | Gender:          |                      |

## APPLICANT CONTACT INFORMATION

|  |                          |   |
|--|--------------------------|---|
| Address:   |                          |   |
| City:  | State:                   | ZIP Code:   |
| Housing Type (Please check one):<br><input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Temporary Quarters <input type="checkbox"/> Homeless<br><input type="checkbox"/> Other Permanent Housing <input type="checkbox"/> Other: _____ | Monthly payment \$ _____ | How long have you been living at your address?<br>_____ month(s) _____ yrs. |
| E-mail Address:  |                          |   |
| Primary Phone Number:  | Secondary Phone Number:  |   |

## APPLICANT DEMOGRAPHIC INFORMATION

**What is your Marital Status (Please select one):**  
 Divorced    Domestic Partner    Married    Separated    Single    Widowed

**What is your Work Status (Please select one)**  
(Individuals 18+) \*

|   |   |
|---|---|
| <input type="checkbox"/> Employed Full-Time           | <input type="checkbox"/> Unemployed (Long-term, more than 6 months) |
| <input type="checkbox"/> Employed Part-Time           | <input type="checkbox"/> Unemployed (Not in Labor Force)            |
| <input type="checkbox"/> Migrant Seasonal Farm Worker | <input type="checkbox"/> Unemployed (Short-term, 6 months or less)  |
| <input type="checkbox"/> Retired                      |   |

**Are you between the age of 14-24 and Not Working or in School?**    Yes    No

**Do you have Health Insurance\*:**    Yes    No

**If yes, please identify what type of Health Insurance:**

|                                   |   |   |
|-----------------------------------|---|---|
| <input type="checkbox"/> None     | <input type="checkbox"/> Badger Care for Children Program | <input type="checkbox"/> Direct Purchase  |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Badger Care for Adults           | <input type="checkbox"/> Employment Based |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Military Health Care             |   |

**Military Status\***    No Affiliation    Active in Military    Veteran

**What is your Primary Language(s)\***    English    Spanish    Hmong    Other:

**Do you need special accommodations in order to receive services at SDC?**  
 Yes    No   If Yes. Please let us know what accommodation you need: \_\_\_\_\_

**Do you need an interpreter\*?**    Yes    No. If Yes, What Language: \_\_\_\_\_

**If you are a single parent, would you like information about Child Support Services\*?**    Yes    No

CR- Social Development Commission is an Equal Opportunity Employer and Service Provider. Auxiliary aids and services are available upon request to individuals with disabilities. If you need this information interpreted to a language you understand or in a different format, please contact La Toya Jones, Equal Opportunity Officer, at 414-906-2823 or [liones@cr-sdc.org](mailto:liones@cr-sdc.org). Callers who are deaf or hearing or speech-impaired may reach us at Wisconsin Relay Number 711. Revised: 03/10/2021

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**Household Size\*:**  One  Two  Three  Four  Five  Six or More

**Please Select your Family Type\***

- Single Person                       Two Adults - No children                       Single Parent Female  
 Single Parent Male                       Two Parent Household                       Non-related Adults with Children  
 Multigenerational Household                       Other

## DEMOGRAPHICS INFORMATION

*Please list all family members living/residing on the address listed above.*

**Education Level\* (Write the letter under the Education category for each family member)**

- A.** 0-8 grade (vocational)    **B.** 9-12/Non Graduate    **C.** High School Graduate/Equivalency Diploma    **D.** 12+Some Post-Secondary  
**E.** 2-4 Year College Graduate    **F.** Graduate of other post-secondary school

**Race\*\* (Write the letter under the Race category for each family member)**

- A.** American Indian or Alaskan Native    **B.** Asian    **C.** Black or African American    **D.** Native Hawaiian/Other Pacific Islander    **E.** White    **F.** Other  
**G.** Multi-Race (any two or more above)

| All Household Members | Relationship     | Birth Date | Gender<br>Female/ Male | Disabled<br>Yes or No | Education Level* | Hispanic/Latino | Race** |
|-----------------------|------------------|------------|------------------------|-----------------------|------------------|-----------------|--------|
| 1.                    | <b>Applicant</b> |            |                        |                       |                  |                 |        |
| 2.                    |                  |            |                        |                       |                  |                 |        |
| 3.                    |                  |            |                        |                       |                  |                 |        |
| 4.                    |                  |            |                        |                       |                  |                 |        |
| 5.                    |                  |            |                        |                       |                  |                 |        |
| 6.                    |                  |            |                        |                       |                  |                 |        |
| 7.                    |                  |            |                        |                       |                  |                 |        |
| 8.                    |                  |            |                        |                       |                  |                 |        |
| 9.                    |                  |            |                        |                       |                  |                 |        |

**\*This number should match the household size question above this sheet.**

**If different from applicant list the name of head of household here?**

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## HOUSEHOLD INCOME INFORMATION

**Instructions:** Complete the bottom boxes for anyone in the household with **income only**. Refer to the list of income sources below. It will help you write the letter that identifies the income source for the category named, **Source of Income**. Write **one** or **all the letters** that apply to the house member's income source. In other words, please include **anyone** who earns income in your home and all their income.

- A. Alimony or Other Spousal Support
- B. Employer
- C. Child Support
- D. Pension
- E. Private Disability Insurance
- F. Retirement Income from Social Security
- G. Self-Employment
- H. Social Security Disability Income (SSDI)
- I. Supplemental Security Income (SSI)
- J. Unemployment
- K. Unemployment Insurance
- L. VA Non-Service Connected Disability
- M. VA Service-Connected Disability Compensation
- N. Wisconsin Works/W-2/TANF
- O. Worker's Compensation
- P. Other

| HOUSEHOLD MEMBER | SOURCE OF INCOME<br><small>List letter(s) from above next to the person who makes income.</small> | EMPLOYER<br>NAME AND ADDRESS | GROSS MONTHLY<br>INCOME |
|------------------|---|------------------------------|-------------------------|
| 1.               |   |                              |                         |
| 2.               |   |                              |                         |
| 3.               |   |                              |                         |
| 4.               |   |                              |                         |

## BENEFITS

**Check if you receive any of the following:**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Food Share (SNAP)            | <input type="checkbox"/> Energy Assistance-LIHEAP | <input type="checkbox"/> Housing Choice Voucher | <input type="checkbox"/> Public Housing   |
| <input type="checkbox"/> Permanent Supportive Housing | <input type="checkbox"/> HUD-VASH                 | <input type="checkbox"/> Childcare Voucher      | <input type="checkbox"/> EITC- Tax Credit |
| <input type="checkbox"/> Affordable Care Act Subsidy  | <input type="checkbox"/> Other: _____             |   |   |

## CERTIFICATION STATEMENT:

By signing below you are certifying that the information provided herein is true and complete. I authorize SDC to review this information and to request and receive information to verify eligibility.

|                            |             |
|----------------------------|-------------|
| Applicant Signature: _____ | Date: _____ |
|----------------------------|-------------|

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## Child Support Information Acknowledgement

I certify that I have received information about Child Support and Contact Information for the Milwaukee County Child Support Services.

Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### Are you interested in any of the following?

- Small Business Start-Up
- Home buying Readiness
- Foreclosure Prevention
- Credit Repair
- Opening a Checking/ Savings Account

- Retirement Readiness
- Employment
- Substance Abuse Counseling
- Mental Health Counseling
- Other Services not listed: \_\_\_\_\_

### SDC Use Only

Date: \_\_\_\_\_ Program: \_\_\_\_\_ SDC Employee: \_\_\_\_\_

If any information, referral, or services were provided. Please describe the outcome below:

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