WIOA DISLOCATED WORKER UNDERSERVED COVID-19 IMPACTED INDIVIDUALS GRANT
WORKER RESILIENCY FUND
INCOME DETERMINATION SELF ATTESTATION FORM

Attachment III

Income Determination Period_____ to Eligibility Determination Date_____
(The 6-month period immediately prior to the eligibility determination date)

FAMILY INCOME WORKSHEET

Names of family members living in household	Relationship to applicant	Age	Income Type	*PERIODS: Indicate Complete Dates (i.e.: 02/23/2020 - 03/22/2020)						Total Gross Income (6 Mos.)
				Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	
				Amount	Amount	Amount	Amount	Amount	Amount	
	Applicant									$
										$
										$
										$
										$
										$
										$

FAMILY SIZE _____ **TOTAL GROSS INCOME: (6 months):** $

*Under "Periods" columns indicate:
1) Period of Month 2) Dollar amounts of income per month

Household 6 Month Salary for 400% FPL is as follows:
Family of 1: $25,520 I Family of 2: $34,480 I Family of 3: $43,440 I Family of 4: $52,400

Meets Income Requirement: ☐ Yes ☐ No

Applicant Certification:
I hereby certify under penalty of perjury that the information on this form is true and accurate and understand that the above information, if misrepresented, or incomplete, may be grounds for immediate program termination and/or penalties as specified by law.

Applicant Signature_____ Date: _____

Staff Certification
I certify that the individual whose signature appears above provided the information recorded on this form.

Staff Name _____

Staff Signature_____ Date:_____