FY 2026-2027 City of Chula Vista CDBG
Therapeutic Recreation Programs, Classes and Special Events
Income limits effective as of 06/02/2016 - Median Income $73,500

Class Enrolling for: _____ Name: _____

Eligibility for this program requires participants to be 18 years of age or older with a severe disability, as defined by the US Census Bureau. The Recreation Department is **required** to gather the following demographic information for each registrant for public services funded with Federal HUD CDBG funds.

Please check your Ethnicity (select only one):
☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Please check your Race (select one or more):

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

Head the Household where the client resides? **Please check one box:**
☐ Male ☐ Female

Check any boxes that apply:
☐ Severely Disabled Adult (per US census, requires verification) ☐ Homeless ☐ Veteran ☐ Senior (age 62+)

Are you a **City of Chula Vista resident?**
☐ Yes ☐ No

Are you limited in English speaking/ writing abilities?
☐ Yes ☐ No

HUD presumes that since you are accessing services funded for severely disabled adults that you fall into the low income category.

Severe disability, as defined by the US Census Bureau, is having one of the following: (a) used a wheelchair or had used another special aid for 6 months or longer; (b) were unable to perform one or more functional activities or needed assistance with an Activity of Daily Living or Instrumental Activity of Daily Living; (c) were prevented from working at a job or doing housework; or (d) had a condition including autism, cerebral palsy, Alzheimer's disease, senility, or mental retardation. Finally, persons who are under 65 years of age and who are covered by Medicare or receive SSI are considered to have a severe disability. Functional activities include seeing, hearing, having one's speech understood, lifting and carrying, walking up a flight of stairs, and walking. Activities of daily living include getting in and out of bed or a chair, bathing, dressing, eating, and toileting. Instrumental Activities of Daily Living include going outside the home, keeping track of money or bills, preparing meals, doing light housework and using the telephone.

However, in order to qualify for these services, the Recreation Department is being asked to collect one of the following to verify:

☐ Statements or letters of severe disability on a physician's/medical professional's letterhead stationary.

☐ Statements records or letters severe disability from a Federal Government Agency that issue or provides disability benefits.

☐ Statements, records or letters severe disability from a State Vocational Rehabilitation Agency counselor.

☐ Certification from a private Vocational Rehabilitation or other Counselor severe disability that issues or provides disability benefits

Participation Agreement:

The City of Chula Vista Therapeutic Recreation program works on specific grant goals with our participants which include and are not limited to functional activities by the participant: independence, socialization, fine and gross motor skills, communication, and activities of daily living. To meet these requirements, we ask parents/caregivers to wait outside of the activity rooms while the participant works on these skills with staff.
If a participant needs a parent/caregiver to communicate on their behalf this will be permitted. If a participant needs assistance with mobility, transitioning, toileting or eating, staff will seek the assistance of the parent/caregiver at that time.

APPLICANT STATEMENT: I hereby certify that the information on this form is accurate and complete. I understand and agree that this self-certification may be subject to further verification by the agency providing services, the City of Chula Vista or the U.S. Department of Housing & Urban Development. I, therefore, authorize such verification, and I will provide supporting documents, if necessary.

_____

Participant or Beneficiary Name (Please Print) Authorized Signature Date

Administrative Use Only:

Approved ☐ Yes ☐ No **Client Intake #**_____

_____

Authorized Staff Name (Please Print) Authorized Signature Date