



NEEDS-BASED STIPEND APPLICATION &

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Office of the City Clerk

AFFIDAVIT OF FINANCIAL WORTH IN SUPPORT OF APPLICATION TO RECEIVE A NEEDS-BASED STIPEND FOR SERVICE ON A BOARD OR COMMISSION

COMPLETE THIS APPLICATION AND AFFIDAVIT TO APPLY FOR A NEEDS BASED STIPEND FOR SERVING ON A CITY BOARD OR COMMISSION. Submit to the Office of the City Clerk, 200 East Santa Clara Street, 14th Floor Tower, San José, California, 95113, Telephone (408) 535-1260, via e-mail at commissions@sanjoseca.gov, or by FAX at (408) 292-6207.

Pursuant to [San Jose Municipal Code Section 2.08.120](#), certain members of City Boards or Commissions established under Chapter 2.08 or the City of San Jose Charter may be eligible for a monthly \$200 Financial Need-Based Stipend. Members of a Low-Income Household, as defined by the U.S. Department of Housing and Urban Development as at or below eighty percent (80%) of the area median income pursuant to 24 C.F.R. Section 92.2, shall be eligible to be paid the sum of two hundred dollars (\$200) per month if they have attended a monthly board or commission meeting. Such members shall be eligible to be paid the stipend even if the monthly board or commission meeting is cancelled. *Note that stipends must be declared as taxable income.*

The City will review and make a final determination of your eligibility for a needs-based stipend payment as soon as possible after submittal of this form. If this Office determines that you are or are not eligible, you will be notified of this finding.

1. List Sources of Monthly Gross Income, including all Sources of Income: (earned income, income payments, rents, spousal support and unemployment compensation.)

Total Monthly Gross Income: _____

2. Please list all household information below: *(Relationship to Head of Household: co-head, spouse, child, etc.)*

	Name (Last, First, MI)	Relationship to Head of Household
1		Head of Household
2		
3		
4		
5		

**You may attach another sheet if you have additional information*

3. Please check this box if you qualify as a member of a low-income household as defined by the chart below:

2024 Santa Clara County Area Median Income (AMI) for Family of 4: \$184,300								
Low Income (80% AMI) Limit as listed in the chart below:								
https://www.hcd.ca.gov/sites/default/files/docs/grants-and-funding/income-limits-2024.pdf (page 12)								
Persons in Family:	1	2	3	4	5	6	7	8
Maximum Income Limit:	102,300	116,900	131,500	146,100	157,800	169,500	181,200	192,900

_____ state that I am eligible for the needs-based stipend for the
Print Name

Commission.

I further swear or affirm that the responses which I have made to the questions and instructions below are true. I acknowledge that the information contained on this application will be part of the public record and may be disclosed if a public records act request is received. Private information such as addresses, and phone numbers will be redacted prior to such release.

I certify (or declare) under the penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature: _____ Date: _____

Print Name: _____ Mailing Address: _____

Phone Number: _____ Email Address: _____

Effective:
5/21/2024