



**Community Action Partnership  
of North Central Missouri (CAPNCM)**

1506 Oklahoma Avenue ~ Trenton, MO 64683

Phone: 1-855-290-8544 ~ Fax: 1-844-503-1872

Website: [www.capncm.org](http://www.capncm.org)

E-mail: [contactus@capncm.org](mailto:contactus@capncm.org)

Dear Applicant,

Thank you for your interest in the Community Action Partnership of North Central Missouri (CAPNCM) Scholarship. We are pleased to offer this scholarship to both new and post graduate students continuing their education beginning in the summer or fall of 2018.

In order for this scholarship to be presented in a timely fashion, it is very important that you complete the following paperwork as soon as possible. **CAREFULLY REVIEW THE FOLLOWING PAGE BEFORE YOU COMPLETE THIS APPLICATION.** These requirements must be met in order to be eligible for the scholarship. You should carefully review the application and the agreements section before signing and submitting.

**Deadline for receiving completed applications in our offices is April 5, 2018 @ 5:00pm.**

You may deliver your application in person to Community Action Partnership of North Central Missouri (CAPNCM) located in Trenton, Missouri or mail it to 1506 Oklahoma Avenue Trenton MO 64683 Attn: CAPNCM Scholarship Program. This application may also be submitted by emailing the completed paperwork to: [shoerrmann@capncm.org](mailto:shoerrmann@capncm.org); if completing and/or submitting online, please remember to attach all other required documentation upon submission.

In order to be considered for this scholarship you must submit an acceptance letter or class schedule proving full-time student status at the college or trade school you have chosen to attend.

The actual scholarship check will be made payable to the recipient. Any decisions of the selection committee will be final.

Sincerely,

Sherry Hoerrmann, Community Services Director  
Community Action Partnership of North Central Missouri

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## **Rules & Guidelines**

CAPNCM will award up to nine (9) scholarships across our nine (9) county service region in the amount of \$1000 per scholarship, per school year.

A committee comprised of CAPNCM staff and Board members will select the grantees. Scholarships will be awarded to up to nine (9) applicants who are, in the opinion of the committee, most deserving of the award from submissions received.

Scholarship Applicants should complete pages 3 - 6 including all essay questions. Parents/Guardians (if applicant is a minor) should complete pages 7 - 14 of the scholarship packet to the best of their ability and include social security cards for all members of the household and 30 days' worth of pay stubs for any working members of the household.

Incomplete and/or late applications will not be considered. Please include all required and signed paperwork, including a copy of your college or trade school acceptance letter when submitting this scholarship application.

## **Eligibility**

Applicants should be full-time students, who reside full-time within one of the following Missouri counties: Caldwell, Daviess, Grundy, Harrison, Linn, Livingston, Mercer, Putnam, or Sullivan and live in an income-qualified household (income qualification to be determined by pages 6-9 of this packet).

Applicants should be qualified for admission to an accredited college, university, or trade school. A minimum of a 2.5 GPA must be maintained to be considered to receive this scholarship.

Both traditional and non-traditional students are welcome to apply.

***Application deadline: April 5, 2018 no later than 5pm***

## **Checklist**

- CAPNCM Assessment Form\*
  - Scholarship Information and Essay Questions
  - College, trade or vocational school acceptance letter and/or class schedule
  - Proof of income for the past 30 days for each member of your household\*
  - Copy of Social Security cards of everyone residing in your household\*
- \*to be completed/provided by parent/guardian if applicant is under 18*

I agree that all requested information contained in this application is attached and accurate.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian (if under 18)

\_\_\_\_\_  
Date

**All questions must be answered fully and accurately. Please type or print in ink.**

\_\_\_\_\_  
Name \_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address

\_\_\_\_\_  
City \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
State Zip County

\_\_\_\_\_  
Home Phone \_\_\_\_\_  
Cell

\_\_\_\_\_  
High School \_\_\_\_\_  
Graduation Date

\_\_\_\_\_  
GPA at time of graduation \_\_\_\_\_  
College entrance score (ACT/SAT)

\_\_\_\_\_  
Name of college you plan to attend \_\_\_\_\_  
Planned Major

Do you currently have any college credit hours? Yes No If so, how many? \_\_\_\_\_

**Family Information**

\_\_\_\_\_  
Mother/Guardian Name \_\_\_\_\_  
Father/Guardian Name

\_\_\_\_\_  
Address \_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Occupation \_\_\_\_\_  
Occupation

\_\_\_\_\_  
Telephone \_\_\_\_\_  
Telephone

School activities, organizations, offices held, etc:

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Community activities, community service projects, organizations, offices held, etc:

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Other scholarships received/applied for and amounts of:

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Your life goals during and after college:

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***Please attach high school transcript.***

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



## Client Confidentiality Agreement / Release of Information / Media Waiver

I certify that the information given on this application is true and accurate to the best of my knowledge and belief. I understand that such information is subject to verification and I further realize that falsified or fraudulent information may result in the rejections of this application.

Under the terms of this Agreement, CLIENT agrees to release to CAPNCM information that is confidential and proprietary to CLIENT (Confidential Information), to be used solely for the Agency's related statistics, services, and programs. Confidential Information refers to any and all information of a confidential, proprietary, or secret nature which is or may be related in any way to the family, medical records, job history, present or future, or CLIENT, or any related data. Confidential Information included, for example, but not limited to: spouses or other family members, ages, salaries, financial standings, criminal records, medical records, and all other pertaining to the family information.

CAPNCM will consider all information received from CLIENT to be strictly confidential, as required by the Privacy Act, and subject to the restrictions of this Agreement; except for information that is: (i) generally known to the public, (ii) in the possession of CAPNCM before receipt from CLIENT, (iii) obtained later by the Agency from a third party without restriction or violation of Agreements.

CAPNCM will not disclose CLIENT's Confidential Information to any other party without the prior written consent of CLIENT, CAPNCM may, however, disclose Confidential Information to its employees and/or programs but only if the employee has a legitimate need to know and has agreed to terms similar to those in this Agreement. CAPNCM may also disclose this Confidential Information (i) to medical personnel in an emergency; (ii) to qualified personnel for research, audits, or program evaluation, as long as CLIENT identities are not identified; (iii) to a third party based on court orders; and (iv) to appropriate authorities in cases of suspected child abuse or neglect. CAPNCM will be responsible for any use or disclosure of Confidential Information by any of its employees or agents to third parties who should not share this information.

I also hereby grant permission to CAPNCM to use my image (photographs and/or video) for use in CAPNCM publications including videos, email blasts, recruiting brochures, newsletters, and magazines and to use my image in electronic versions of the same publications or on the CAPNCM website or other electronic forms of media.

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Please check the paragraph below which is applicable to your present situation:

\_\_\_\_ I am 18 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release.

\_\_\_\_ I am the parent or legal guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release.

Client Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

Child's Name (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

Interviewer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## Household Income

Please list ALL sources of income for ALL household members.

Household Member's Name	Source of Income*	Amount of Income	How Often Received

\*Wages; Self-Employment; Pensions; Social Security; SSI; Child Support; TANF, Other

## Non-Cash Benefits

Household Member's Name	Source of Benefit*	Amount of Benefit	How Often Received

\*SNAP; TANF Child Care; TANF Transportation; Section 8/HUD Rental Assistance; WIC; Other

**Do you rent or own your home?**

Rent       Own

**Is any person in the household ordered to RECEIVE child support?**

Yes       No      If yes, how much? \_\_\_\_\_

**Child Support Case Number:**

\_\_\_\_\_

**Does your family currently receive food stamps?**

Yes       No       Applied/Waiting       Denied





# CAPNCM COMMUNITY SERVICES APPLICATION

## How would you describe your family's current housing situation?

- No Subsidy; Own or Rent
- Subsidized
- Living with friends or relatives
- At risk of homelessness (eviction notice/temporary)
- Homeless

## What is your family's current household income and how would you rate your money management practice?

- Able to pay all bills and save
- Sufficient income to pay bills without subsidies
- Income meets most financial obligations (may include subsidies)
- Some income; budget includes subsidies
- No income; no budget

## How would you describe your family's current employment situation, including status, skill set, benefits, and how it meets basic needs?

- Full-time employment above minimum wage
- Full-time employment with minimum wage
- Part-time employment
- Unemployed with skill and/or previous work history
- Unemployed with no skill and/or previous work history
- Retired or Disabled

## How would you describe your family's mode of transportation, including reliability, insurance, and licensing?

- Public or private transportation always available
- Public or private transportation available most of the time
- Public or private transportation available some of the time
- Public or private transportation rarely available
- No transportation available

## How would you describe your family's current physical and oral health situation, including insurance and ability to pay for medications?

- No physical health problems
- Does not interfere with goals
- Occasionally interfere with employment or other goals
- Regularly interfere with goals
- Prohibit goals

## Are mental health and/or substance abuse issues present in the family, and if so, how are they being addressed?

- All basic needs met
- Most basic needs met
- Some basic needs met
- Rarely basic needs met
- No basic needs met (emergent situation)



# CAPNCM COMMUNITY SERVICES APPLICATION

Household Comments:	Individual Comments:
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## CLIENT CONFIDENTIALITY AGREEMENT / RELEASE OF INFORMATION

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This agreement may be amended only in writing and shall be governed by the laws of the State of Missouri.

**Please sign below to indicate that you have read this Consent and agree with its terms.**

Client Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

Interviewer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# MISSOURI COMMUNITY ACTION MANAGEMENT INFORMATION SYSTEM

## **Client Consent – Release of Information**

The Missouri Community Action Management Information System (MIS) serves Missouri’s Community Action Agencies, a network of partner agencies working together to provide service to low-income individuals and families in Missouri.

The information that is collected in the (MIS) database is protected by limiting access to the database and by limiting with whom the information may be shared, in compliance with the standards set forth in the Health Insurance Portability and Accountability Act (HIPAA). Every person and agency that is authorized to read or enter information into the databases has signed an agreement to maintain the security and confidentiality of the information. Any person or agency that is found to violate their agreement may have their access rights terminated and may be subject to further penalties.

### **BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:**

I authorize partner agencies and their representatives to share the following information regarding my family/household and me. I understand this information is for the purpose of assessing our needs for employment, housing, utility assistance, food, counseling and/or other services.

The information may consist of the following:

- My financial situation, to include the amount of my income, and savings of money and/or food stamps I may have.
- This information may also include debts I owe for utilities, rent, etc.
- Identifying and/or historical information regarding myself and members of my family/household.

### **I UNDERSTAND THAT:**

- Information I give concerning physical or mental health problems will not be shared with other partner agencies in any way that identifies me.
- The partner agencies have signed agreements to treat my information in a professional and confidential manner. I have the right to view the client confidentiality policies used by the MIS.
- Staff members of partner agencies who will see my information have signed agreements to maintain confidentiality regarding my information.
- I have the right to request information about who has accessed my information.
- The partner agencies may share non-identifying information about the people they serve with other parities working to end poverty.
- The release of my information for MIS does not guarantee that I will receive assistance, and my refusal to authorize the use of my identifying information does not disqualify me from receiving assistance.
- This authorization will remain in effect unless I revoke it in writing, and I may revoke authorization at any time by signing a written statement available at any partner agency.
- If I revoke my authorization all identifying information already in the database will remain, but will no longer be shared with partner agencies.

**Partner Agencies:** A list of the partner agencies within the Statewide Community Action Network may be viewed prior to signing this form.

_____	<u>X</u> _____	_____
Client Name (please print)	Client Signature	Date
_____		
Social Security Number		
_____	_____	_____
Agency Personnel Name (please print)	Agency Personnel Signature	Date

**COMMUNITY ACTION PARTNERSHIP OF NORTH CENTRAL MISSOURI**

1506 Oklahoma Avenue, Trenton, MO 64683

Phone 855-290-8544 | Fax 844-503-1872

Extensions 1021 & 1023

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

County: \_\_\_\_\_

Number in Household: \_\_\_\_\_

\_\_\_\_\_  
Head of Household

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address

\_\_\_\_\_  
Person Making Application

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Name(s) of Additional Family Members

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Source of Income

\_\_\_\_\_  
Monthly Amount

X 12=

\_\_\_\_\_  
Annual Amount

Briefly Explain the Emergency: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Amount Needed \$ \_\_\_\_\_

\_\_\_\_\_  
Vendor Name and Address

Second Amount Needed if Applicable: \$ \_\_\_\_\_

\_\_\_\_\_  
Vendor #2 Name and Address

#####

I certify that the above information is true and complete and I release from liability any representative of Community Action Partnership of North Central Missouri in securing verification and information pertaining to this request. I verify that I have not obtained other assistance for this emergency unless I have specified this.

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee's Signature

#####

Date Paid \_\_\_\_\_ To Whom: \_\_\_\_\_ Amount \$ \_\_\_\_\_ Check # \_\_\_\_\_

Date Paid \_\_\_\_\_ To Whom: \_\_\_\_\_ Amount \$ \_\_\_\_\_ Check # \_\_\_\_\_

Funding Source Used: \_\_\_\_\_

Funding Source Used: \_\_\_\_\_

# CSBG Zero Income Determination

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please help us to understand how you have been managing with little to no income by answering the following:

1) When did you last receive money? Who was it from and how much was it?

\_\_\_\_\_

2) Do you have savings or other resources?  Yes  No

If yes, where are these resources located and what is their approximate value?

\_\_\_\_\_

3) Do you receive money from relatives or friends?  Yes  No

If yes, how often is this received, how much is received, and from whom?

\_\_\_\_\_

4) Do you work odd jobs?  Yes  No

If yes, what is the job, how much are you paid, and when were you last paid?

\_\_\_\_\_

5) How have the rent/house payments & utilities (gas, electric, water, etc.) been paid for the last three months?

\_\_\_\_\_

6) Have you applied for food stamps?  Yes  No

If no, why not?

\_\_\_\_\_

7) How do you pay for food and transportation expenses?

\_\_\_\_\_

**I/We certify this information is correct to the best of my/our knowledge.**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Spouse/Other Adult

\_\_\_\_\_  
Staff Signature