Community Action Partnership of North Central Missouri
1506 Oklahoma Avenue ~ Trenton, MO 64683
Toll-free Phone: 1-855-290-8544
Toll-free Fax: 1-844-503-1872
www.capncm.org ~ email: contactus@capncm.org

COMMUNITY SERVICES APPLICATION

When applying for Community Services fill all sheets out completely and sign where indicated. If there is NO income of any kind in the household, the Zero Income Form will also need to be completed.

Return this packet along with the following:

- ☐ Proof of ALL income for the past 30 days
  (current SS award letter or bank statement showing current deposit, pay stubs, etc)
- ☐ Copy of Social Security cards for everyone in the home
- ☐ Copy of the bill you need assistance paying (if applicable)

Questions?
Call 855-290-8544
Fax 844-503-1872
ext. 1021 or ext. 1023

CAPNCM COMMUNITY SERVICES APPLICATION

Physical Address: _____ City, State, Zip: _____

Mailing Address (if different from above): _____ City, State, Zip: _____

Phone Number: _____ Alternate/Cell Number: _____ May We Text You? Yes or No (Circle One) *standard text rates apply*

Email: _____ May We Email You? Yes or No (Circle One)

Name (First, Middle, Last)	SSN	DOB	M/F	Relation	Marital Status	Race*	Veteran (Y/N)	Highest Education Level Completed**	Currently Receiving Disability (Y/N)	Health Insurance Type***
Example: Jane Doe	*000-00-0000*	*00/00/00*	*F*	*self*	*M*	*C*	*Y*	*GED*	*N*	*None*
1)				Self						
2)										
3)										
4)										
5)										
6)										
7)										
8)										
9)										

Please choose from the following answers for these categories.

*Race: Caucasian; African American; Hispanic/Latino; American Indian/Alaska Native; Native Hawaiian/Pacific Islander; Asian; Other; Refuse to Answer

** Education: No High School; Some High School; High School Diploma; GED; Some College; Technical Certification; Associate's Degree; Bachelor's Degree; Advanced Degree; Refuse to Answer

***Insurance: None; Medicaid; Medicare; VA Services; Other State Health Insurance; Employer Provided; COBRA; Private Insurance; Indian Health Services Program; Refuse to Answer

Attach additional sheets of paper if necessary for listing additional household members.

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 ☐ Other Housing _____

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 (*HUD, Section 8, Low-Income Housing*)
☐ 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

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?

☐ No mental health problems
☐ Does not interfere with goals
☐ Occasionally interferes with goals
☐ Regularly interferes with goals
☐ Prohibits goals

How would you describe your family's regular food, nutrition, and clothing situation?

☐ Able to afford food without food programs
☐ Able to afford some food without food programs
☐ Unable to afford food without food program assistance; SNAP (food stamps), WIC etc.
☐ Unable to afford food without food program assistance; food bank
☐ Unable to afford or obtain food

How would you describe your academic skill set and how it impacts employment or other goal attainment?

☐ Master's / Doctorate
☐ 2 or 4 year degree or certification
☐ Some college tech training
☐ High School/Hi Set (GED)
☐ Did not graduate High School

ADDITIONAL INFORMATION / REFERRALS

I would like more information on the following CAPNCM programs:

☐ Offender Empowerment
☐ Housing Development/Home Repair
☐ Weatherization
☐ Section 8/HUD Housing
☐ Missouri Work Assistance
☐ Health Services Clinics
☐ CAPNCM Rentals
☐ Energy Assistance

Any issues or problems needing help with that are not listed above:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

CAPNCM COMMUNITY SERVICES APPLICATION

Household Comments:	Individual Comments:

CLIENT CONFIDENTIALITY AGREEMENT / RELEASE OF INFORMATION

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 rejection 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 includes, 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. The Community Action Agency 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 a 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.

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.
- Indentifying 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.

_____	_____	_____
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

_____ _____ _____ X 12= _____
Telephone Number Source of Income Monthly Amount 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: _____

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.

_____ _____
Client Signature Spouse/Other Adult

_____
Staff Signature