NEED QUESTIONNAIRE

Name:________________________________ **Phone Number:**________________________

Please answer the following questions:

Are you a military veteran? ☐ **Yes** ☐ **No**

Are you homeless? ☐ **Yes** ☐ **No**

Are you being evicted? ☐ **Yes** ☐ **No**

Are your utilities past due? ☐ **Yes** ☐ **No**

Have you been approved for heating assistance through social services?
☐ **Yes** ☐ **No**

Amount Due	Utility Company Name	Account Number

If you are needing assistance that is not listed, describe the need:

___I understand that in consideration of agency's assistance with my situation, I agree to hold harmless Community Action Partnership and its agent and/or its employees from all claims or causes of actions arising, or which may arise from mistakes, errors, or omissions in regards to said assistance.

___I understand that if I am requesting housing assistance the property may be required to pass a safety inspection and all paperwork <u>must be completed</u> before approval of the security deposit payment.

___I understand that if I sign the lease or move in prior to the inspection or approval of the housing assistance, the housing assistance application will be voided.

____ ________________

Signature Date

Revised 10/2019

DICKINSON OFFICE: 202 EAST VILLARD, DICKINSON, NORTH DAKOTA 58601
Phone (701) 227 - 0131 • Fax (701) 227 - 4750
WILLISTON OFFICE: 120 WASHINGTON AVENUE, WILLISTON, NORTH DAKOTA 58801
Phone (701) 572 - 8191 • Fax (701) 572 - 8192

Head of Household Information

First Name MI Last Name	Birth Date	Social Security Number	Gender	Phone Number
	/ /	- -	❒ M ❒ F	

Education	Disabled	Race	Ethnicity
❒ 0-8th ❒ 9th-12th non-grad ❒ GED ❒ HS grad ❒ 12th grade + some Post-Secondary ❒ 2- or 4-years College Graduate ❒ Graduate of other Post-Secondary	❒ Yes ❒ No	❒ American Indian / Alaska Native ❒ Asian ❒ Black / African American ❒ Native Hawaiian / Other Pacific Islander ❒ White ❒ Other: ___________________________ ❒ Multi-race (two or more of the above)	❒ Hispanic ❒ Non-Hispanic

Work Status	Health Coverage		Military Status
❒ Full Time ❒ Part Time ❒ Retired ❒ Migrant Seasonal Farm Worker ❒ Unemployed (6 months or less) ❒ Unemployed (6 months +) ❒ Unemployed (Not in labor force)	❒ Medicaid ❒ Medicare ❒ Military Health Care ❒ Employment Based ❒ Direct Purchase	❒ State Children ❒ State Adult ❒ Other: _________________ ❒ None	❒ Active ❒ No Affiliation ❒ Veteran

Housing Information

Address	City / State / Zip	County
❒ This is also my mailing address		

# in Household	Family Type		Housing Status	
	❒ Single Person ❒ Single Parent Female ❒ Single Parent Male ❒ Non-related Adults with Children	❒ Two Adults - No Children ❒ Multigenerational Household ❒ Two Parent Household ❒ Other: __________________	❒ Own ❒ Rent ❒ Other Permanent housing	❒ Homeless ❒ Other

Contact Preference	❒ Phone ❒ Mail ❒ Email: ____

Income Information

What income do you receive?	How much?	How often?	What benefits do you receive?	How much?	How often?
❒ Employment	$		❒ SNAP	$	
❒ Social Security ❒ SSI ❒ SSDI	$		❒ WIC	$	
❒ VA ❒ Service-Connected ❒ Non-Service Connected	$		❒ LIHEAP	$	
			❒ Housing Choice Voucher (Section 8)	$	
❒ Child Support	$		❒ Public Housing	$	
❒ Alimony / Spousal Support	$		❒ Permanent Supportive Housing	$	
❒ TANF	$		❒ HUD-VASH	$	
❒ Private Disability Insurance	$		❒ Childcare Voucher	$	
❒ Pension / Retirement	$		❒ Affordable Care Act Subsidy	$	
❒ Worker's Compensation	$		❒ Other: ____________________	$	
❒ Unemployment	$		❒ I have no income at this time (initial here): ________________		
❒ Other: _________________	$		CAP Staff Initial: ________________		

Additional Household Members

First Name		First Name	
Last Name		Last Name	
Relationship to Head of Household		Relationship to Head of Household	
Birth Date	/ /	Birth Date	/ /
Social Security #	- -	Social Security #	- -
Gender	☐ Male ☐ Female	Gender	☐ Male ☐ Female
Highest Level of Education		Highest Level of Education	
Disabled?	☐ Yes ☐ No	Disabled?	☐ Yes ☐ No
Primary Race		Primary Race	
Ethnicity	☐ Hispanic ☐ Non-Hispanic	Ethnicity	☐ Hispanic ☐ Non-Hispanic
Work Status		Work Status	
Medical Coverage		Medical Coverage	
Income Type		Income Type	
Income Amount		Income Amount	
Initial here if you have no income.		Initial here if you have no income.	

First Name		First Name	
Last Name		Last Name	
Relationship to Head of Household		Relationship to Head of Household	
Birth Date	/ /	Birth Date	/ /
Social Security #	- -	Social Security #	- -
Gender	☐ Male ☐ Female	Gender	☐ Male ☐ Female
Highest Level of Education		Highest Level of Education	
Disabled?	☐ Yes ☐ No	Disabled?	☐ Yes ☐ No
Primary Race		Primary Race	
Ethnicity	☐ Hispanic ☐ Non-Hispanic	Ethnicity	☐ Hispanic ☐ Non-Hispanic
Work Status		Work Status	
Medical Coverage		Medical Coverage	
Income Type		Income Type	
Income Amount		Income Amount	
Initial here if you have no income.		Initial here if you have no income.	

Client Certification: My signature below signifies that the information provided by me to establish household eligibility is true and accurate to the best of my knowledge; I consent to the independent verification of the information by the authorized agent of the agency or its government funding source; and I consent to the review of my files by the authorized agent of the agency or its governing funding source.

____ _____________________________

Client Signature Date

COMMUNITY ACTION PARTNERSHIP REGIONS I & VIII

120 Washington Ave, Williston, ND, 58801 P: (701) 572-8191 F: (701) 572-8192
202 E. Villard, Dickinson, ND 58601 P: (701) 227-0131 F: (701) 227-4750

AUTHORIZATION FOR RELEASE OF INFORMATION – CLIENT SERVICES

Client Name:	Social Security Number:	Date of Birth:
Street Address:	City/State/Zip Code:	

I hereby authorize Community Action Partnership to release information to or obtain information from those initialed below:

_____ Banks/Financial Institutions

_____ CAP Client Management System

_____ Child Support Division

_____ Courts and Post Offices

_____ Credit Providers/Credit Bureaus

_____ Employers

_____ Human Service Center

_____ Landlords/PHAs

_____ Lodging (hotels, motels, shelters)

_____ Military & VA

_____ Schools & Colleges

_____ Social Security Administration

_____ Social Services

_____ Unemployment Division/Job Service

_____ Utility Companies

_____ Workforce Safety

The following information is to be released or requested: verification of income, employment verification, asset verification, bank statements, verification of benefits, rent payment amount, security deposit amount, rental lease. Other: ____

Intake Form: The following information will be requested: social security number, name, birth date, sex, disabled, marital status, sex/age of family/household members, race, ethnicity, veteran status, education, employment, income status, housing information, health coverage, services currently receiving, unmet needs.

This authorization is voluntary and remains in effect for twelve (12) months from the date it is signed, unless specifically revoked by written notice to the agency or person, as indicated below (Specific event terminating the Release of Information or date to terminate the agreement.): ___________________________________

Client Consent: Any information release prior to the written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this release is as effective as the original.

____

Signature of Client Date

____

Signature of Staff Date