Helping People. Changing Lives.
community Action PARTNERSHIP
NORTH DAKOTA'S POVERTY FIGHTING NETWORK
DICKINSON/WILLISTON REGIONS

Need Questionnaire
Signature Required on Page 2

Name: _____ **Phone Number:** _____

Email: _____

An application for assistance does not ensure financial assistance.

Please answer the following questions:

1. Are you a military veteran? ☐ Yes ☐ No
2. Are you homeless? ☐ Yes ☐ No
3. Were you financially impacted by COVID-19? ☐ Yes ☐ No
   a. Business Closed? ☐ Yes ☐ No
   b. Job loss? ☐ Yes ☐ No
   c. Furloughed or Reduced hours? ☐ Yes ☐ No
   d. Last Date Worked: _____
   e. Other? _____
4. Is your rent past due? ☐ Yes ☐ No
   a. How many months behind are you? _____
5. Are you being evicted? ☐ Yes ☐ No
   a. Did you receive written notice? ☐ Yes ☐ No
6. Do you have a lease? ☐ Yes ☐ No
   a. Landlord Name: _____
   b. Phone Number: _____
   c. What is your monthly rent payment? _____
   d. Number of bedrooms: _____
   e. Is this your primary residence? ☐ Yes ☐ No
7. Are your utilities past due? ☐ Yes ☐ No
   a. How many months behind are you? _____

Amount Due	Company Name	Account Number

8. Have you been approved for Unemployment? ☐ Yes ☐ No
   a. Start date: _____
   b. Amount per week: _____
   c. For How many weeks? _____

Continued on Page 2

EQUAL HOUSING OPPORTUNITY

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Need Questionnaire
Signature Required at Bottom of Page

9. Have you been approved for any of the following?
   a. LIHEAP (heating assistance) ☐ Yes ☐ No
   b. Medicaid/Medicaid Expansion ☐ Yes ☐ No
   c. SNAP (food stamps) ☐ Yes ☐ No
   d. WIC ☐ Yes ☐ No
10. 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 Community Action Partnership may not be able to make payment in full and I may be required to make a copayment towards the outstanding debt.

___I understand that if I am requesting housing assistance the property may be required to pass a safety inspection and all paperwork must be completed 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**

AGENCY USE ONLY:

EQUAL HOUSING OPPORTUNITY

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

Helping People. Changing Lives.
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NORTH DAKOTA'S POVERTY FIGHTING NETWORK
DICKINSON/WILLISTON REGIONS

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

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

Housing Information

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

# in Household	Family Type		Housing Status	
	❒ Single Person	❒ Two Adults - No Children	❒ Own	❒ Homeless
	❒ Single Parent Female	❒ Multigenerational Household	❒ Rent	❒ Other
	❒ Single Parent Male	❒ Two Parent Household	❒ Other Permanent housing	
	❒ Non-related Adults with Children	❒ 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	$		❒ LIHEAP	$	
❒ Non-Service Connected			❒ 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	
Last Name	
Relationship to Head of Household	
Birth Date	/ /
Social Security #	- -
Gender	☐ Male ☐ Female
Highest Level of Education	
Disabled?	☐ Yes ☐ No
Primary Race	
Ethnicity	☐ Hispanic ☐ Non-Hispanic
Work Status	
Medical Coverage	
Income Type	
Income Amount	
Initial here if you have no income.	

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

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

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

AUTHORIZATION FOR RELEASE OF INFORMATION – CLIENT SERVICES/PAYEE SERVICES
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

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

CHOOSE ONE OPTION BELOW:

☐ By marking this box, I hereby authorize Community Action Partnership to release information to or obtain information from all those listed below.

OR

I hereby authorize Community Action Partnership to release information to or obtain information ONLY for the agencies/organizations that I have marked below.

____ CAP Client Data System	____ Child Support Division	____ Courts and Post Offices
____ Credit Providers/Bureaus	____ Employers	____ Enforcement Agencies
____ Financial Institutions	____ Health Insurance Providers	____ Human Service Center
____ Landlords/PHAs	____ Legal Assistance	____ Lodging (hotels, motels, shelters)
____ Medical Providers	____ Military & VA	____ Pharmacy
____ Retirement Systems	____ Schools & Colleges	____ Social Security Administration
____ Social Services	____ Unemployment/Job Service	____ Utility Companies
____ Workforce Safety	____ Hospital/Clinic:_____	

____ Other/Family Member: _____

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