

PLEASE READ BEFORE COMPLETING APPLICATION FOR ASSISTANCE:
DOCUMENTS REQUIRED

Your request for assistance is considered incomplete and pending until you provided the requested documentation listed below.

Within 5 business days after submitting your application, you will be contacted by telephone. Please be sure your phone voice mail box is set up and able to accept messages.

Please note: an application for assistance is not a guarantee of assistance.

Complete and submit the attached forms and documentation listed below for a complete application.

You may scan the documents with a desk scanner or make photocopies. Photographs are acceptable, but we may ask for the document if the photo is not readable.

PLEASE SIGN/INITIAL ALL PAGES THAT ASK FOR YOUR SIGNATURE OR INITIAL.

INCLUDE COPIES OF THE FOLLOWING:

- **Picture ID** (Driver's License, Identification Card, School Photo ID, etc.) for household members 18 years of age and older
- **Proof of earned and/unearned income** received in the last thirty (30) days for all household members 18 years and older, such as:
 - Pay stubs or other proof (bank statement showing direct deposit) that you receive earned income: 4 stubs if paid weekly, 2-3 stubs if paid bi-weekly, 2 stubs if paid twice a month or 1 stub if paid monthly. Do not submit W2 Tax forms.
 - Benefit award letter(s) (Social Security, SSI/SSDI, VA, TANF, etc.)
 - Pension/royalty statements
 - Cash payment ledger or payment receipts if you are paid in cash
 - Proof of child support payments
 - Unemployment payment history
 - Worker's compensation payments
- **Proof of Hardship:**
 - Past due utilities: include a copy of your current utility bill (s) - front and back - and any disconnection notices for: electric, gas, or water.
 - Past-due rent: please include your landlord's name and phone number, rent ledger and any notices you have received about your past due rent.
 - Security Deposit: please include landlord's name and phone number.

Updated 2021.08

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	
			/ /	- -	<input type="checkbox"/> M <input type="checkbox"/> F		
Education		Disabled	Race		Ethnicity		
<input type="checkbox"/> 0-8 th <input type="checkbox"/> 9 th -12 th non-grad <input type="checkbox"/> GED <input type="checkbox"/> HS grad <input type="checkbox"/> 12 th grade + some Post-Secondary <input type="checkbox"/> 2- or 4-years College Graduate <input type="checkbox"/> Graduate of other Post-Secondary		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black / African American <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other: _____ <input type="checkbox"/> Multi-race (two or more of the above)		<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		
Work Status		Health Coverage			Military Status		
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Unemployed (6 months or less) <input type="checkbox"/> Unemployed (6 months +) <input type="checkbox"/> Unemployed (Not in labor force)		<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Military Health Care <input type="checkbox"/> Employment Based <input type="checkbox"/> Direct Purchase	<input type="checkbox"/> State Children <input type="checkbox"/> State Adult <input type="checkbox"/> Other: _____ <input type="checkbox"/> None			<input type="checkbox"/> Active <input type="checkbox"/> No Affiliation <input type="checkbox"/> Veteran	
Housing Information							
Address			City / State / Zip		County		
<input type="checkbox"/> This is also my mailing address							
# in Household	Family Type			Housing Status			
	<input type="checkbox"/> Single Person <input type="checkbox"/> Single Parent Female <input type="checkbox"/> Single Parent Male <input type="checkbox"/> Non-related Adults with Children			<input type="checkbox"/> Two Adults - No Children <input type="checkbox"/> Multigenerational Household <input type="checkbox"/> Two Parent Household <input type="checkbox"/> Other: _____		<input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Other Permanent housing	
Contact Preference		<input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email: _____					
Income Information							
What income do <u>you</u> receive?	How much?	How often?	What benefits do <u>you</u> receive?	How much?	How often?		
<input type="checkbox"/> Employment	\$		<input type="checkbox"/> SNAP	\$			
<input type="checkbox"/> Social Security <input type="checkbox"/> SSI <input type="checkbox"/> SSDI	\$		<input type="checkbox"/> WIC	\$			
<input type="checkbox"/> VA <input type="checkbox"/> Service-Connected <input type="checkbox"/> Non-Service Connected	\$		<input type="checkbox"/> LIHEAP	\$			
<input type="checkbox"/> Child Support	\$		<input type="checkbox"/> Housing Choice Voucher (Section 8)	\$			
<input type="checkbox"/> Alimony / Spousal Support	\$		<input type="checkbox"/> Public Housing	\$			
<input type="checkbox"/> TANF	\$		<input type="checkbox"/> Permanent Supportive Housing	\$			
<input type="checkbox"/> Private Disability Insurance	\$		<input type="checkbox"/> HUD-VASH	\$			
<input type="checkbox"/> Pension / Retirement	\$		<input type="checkbox"/> Childcare Voucher	\$			
<input type="checkbox"/> Worker's Compensation	\$		<input type="checkbox"/> Affordable Care Act Subsidy	\$			
<input type="checkbox"/> Unemployment	\$		<input type="checkbox"/> Other: _____	\$			
<input type="checkbox"/> Other: _____	\$		<input type="checkbox"/> I have no income at this time (initial here): _____ CAP Staff Initial: _____				



Additional Household Members

First Name	
Last Name	
Relationship to Head of Household	
Birth Date	/ /
Social Security #	- -
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Highest Level of Education	
Disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Race	
Ethnicity	<input type="checkbox"/> Hispanic <input type="checkbox"/> 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	<input type="checkbox"/> Male <input type="checkbox"/> Female
Highest Level of Education	
Disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Race	
Ethnicity	<input type="checkbox"/> Hispanic <input type="checkbox"/> 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	<input type="checkbox"/> Male <input type="checkbox"/> Female
Highest Level of Education	
Disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Race	
Ethnicity	<input type="checkbox"/> Hispanic <input type="checkbox"/> 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	<input type="checkbox"/> Male <input type="checkbox"/> Female
Highest Level of Education	
Disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Race	
Ethnicity	<input type="checkbox"/> Hispanic <input type="checkbox"/> 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.

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

Need Assessment/Application for Assistance

Name: _____ Phone Number: _____

Email: _____

An application for assistance does not guarantee financial assistance

- 1. Are you a US military veteran? Yes No
- 2. Are you homeless? Yes No

RENT/ SECURITY DEPOSIT

- 3. Are you applying for a security deposit? Yes No
- 4. Are you applying for rental assistance? Yes No
- 5. Is your rent past due? Yes No
 - a. How many months behind are you? _____
- 6. Do you have a written lease? Yes No
- 7. Are you being evicted? Yes No
 - a. Did you receive written notice? Yes No

8. Please answer the following:

- 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

- 9. Have you applied for North Dakota Rent Help? Yes No
 - a. Status of application: Denied Approved Pending

UTILITIES/WATER BILLS

- 10. Are you applying for utility assistance? Yes No
- 11. Are your utilities past due? Yes No
 - a. How many months behind are you? _____

Utility Company/Water Bill Information	Account Number	Amount Due



Need Assessment/Application for Assistance

COVID/FINANCIAL HARDSHIP SINCE MARCH 2020:

12. 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? _____

OTHER BENEFITS

13. Have you received /been approved for Unemployment? Yes No
- a. Start date: _____
- b. Amount per week: _____
- c. For how many weeks? _____

14. Have you applied for/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

15. Please describe your current situation, including any additional information that you think will help us review your application. If you currently do not have income, explain how you are meeting your daily basic needs (food, gas for car, etc.).

Need Assessment/Application for Assistance

___ 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 need to pass a safety/habitability 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