

**COMMUNITY ACTION COUNCIL OF HOWARD COUNTY  
APPLICATION FOR ASSISTANCE**

**CUSTOMER INFORMATION**

Form CAC 100 July 1, 2005

		Family Type:	Single Parent Female, Single Parent Male, Two-Parent, Single Person, Two Adults (No Children), Foster Parent, Guardian		
Last Name:	First:	Middle:	Suffix:		
Social Security Number:		Date of Birth:			
Primary Phone Number:		Other Phone Number:			

**HOUSEHOLD INFORMATION**

Address:		Apt Number:	Monthly Cost:
City:	State:	Zip Code:	
Type of Home:	Apartment/Multifamily, Mobile Home, 1 Story Single Family, 2 or 3 Story Single Family, Single Family Row or Town House		
If Homeless – Prior Residence Type:	How Long There?	Zip Code:	

**DEMOGRAPHIC INFORMATION**

Name	Social Security Number	Date of Birth	Gender (M/F)	Ethnicity (Hispanic?)	Race	Marital Status	Educational Level	US Citizen (Y/N)	Disability (Y/N)	Language spoken in the home other than English
Last                      First					Black White Asian Pacific Islander Native American/Alaskan Bi-Racial	N/A (Child) Divorced Married Never Married Separated Widowed Unknown				

**ASSISTANCE INFORMATION**

Name	Currently Receiving:											Currently is:						
	Food Stamps	Medical Assistance	MCHIP	WIC	TCA	TANF Child Care	TANF Transportation	VA Medical Services	Pension	Medicare	Housing Subsidy	Migrant Worker	Seasonal Farm Wkr	Homebound	Military Family	Veteran	Teen Parent	Pregnant
Last                      First																		

**INCOME INFORMATION**

Name	Employment Status	Hours worked last week	Employer	Income from Employment	Pay Interval	Additional Income Sources	Amount of Income	Interval
	Full Time, Part Time, Unemployed, Training or School, Disabled or Retired				Weekly Bi-Weekly Monthly	Child Support, TCA, SSI, etc.		Weekly Bi-Weekly Monthly

**APPLICANT CERTIFICATION**

I certify that the information I have provided is true and correct. I understand that misinformation or refusal to disclose information which is essential for a determination of eligibility is a basis for disapproval of my application. Also, I hereby authorize Community Action Council of Howard County to verify/obtain any information and documentation which will assist in determining my eligibility for assistance.

APPLICANT SIGNATURE:	DATE:
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**PROGRAM APPLICATION INFORMATION – Sign and Date to indicate the program(s) for which you are making application.**

	Signature:	Date:	Application Taken By:
Food Bank			
Eviction Prevention			
First Month's Rent			
EAFC			
Rental Allowance Program			
Fuel Fund			
William Bailey Fund			
Trash Collection Fee			
MEAP/EUSP			
Other			

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**RIGHT APPEAL AND TO A GRIEVANCE HEARING**

You have the right to appeal if services are denied or terminated. CAC will make every effort to resolve your concerns prior to a formal grievance process.

I understand and acknowledge I have the right to a grievance hearing if services for which I apply are denied.

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

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**For Office Use Only:**  
**DATA ENTRY**

	Date Entered:	Entered By:
Intake		
Registration		
Case Management		
Eligibility		
Certification		
Enrollment		
Service Units		

**ASSESSMENT**

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

Additional Information Required (Y/N): \_\_\_\_\_ Date: \_\_\_\_\_ Request for Additional Information Given (Y/N): \_\_\_\_\_

Not Eligible: \_\_\_\_\_ Reason: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Eligible: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CERTIFICATION OF ELIGIBILITY**

Supervisor: \_\_\_\_\_

Additional Information Required (Y/N): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Not Eligible: \_\_\_\_\_ Reason: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Eligible: \_\_\_\_\_ Date: \_\_\_\_\_ Program: \_\_\_\_\_ Signature: \_\_\_\_\_

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**For Food Bank use only:**

**REFERRAL**

Date: \_\_\_\_\_ Agency: \_\_\_\_\_ Worker: \_\_\_\_\_

Date of Previous Referral: \_\_\_\_\_ Eligible (Y/N): \_\_\_\_\_ Signature of Worker: \_\_\_\_\_

**SERVICE**

Worker: \_\_\_\_\_ Date Service Provided: \_\_\_\_\_ Amount of Food \_\_\_\_\_ lbs.