



SENDCAA's Financial Assistance Programs

What you need to apply for assistance?

Please fill out the following application as completely as possible*. In addition the following information is needed to process your application, depending on the type of assistance you are applying for:

If you are applying for Energy Share, please also include:

- SFN 62-Emergency Assistance Application, which is attached to the Energy Share Application
- Your LIHEAP approval letter (if you haven't applied for LIHEAP, please visit your county social service office to apply)
- Proof of all income (30 days of paystubs, child support, unemployment, TANF, SNAP (Food Stamp) Benefits, etc.)
- Photo ID
- Copy of your Disconnect notice from your electric company

If you are applying for Rental Assistance, please also include:

- Proof of all income (30 days of paystubs, child support, unemployment, TANF, SNAP (Food Stamp) Benefits, etc.)
- Photo ID
- A copy of your lease
- Current Eviction Notice
- **Approval of Rental Assistance is contingent on available funding**

*Please note that the more information that is provided with your application will assist in the processing time of your application.

Once we receive your application, we will contact you via phone or email

Please contact us with any questions at the toll free number below

Sincerely,

SENDCAA Self-Sufficiency Staff

3233 South University Drive, Fargo, ND 58104-6221
Phone (701) 232-2542 Toll Free (800) 726-7960 Fax (701) 298-3115
Website www.sendcaa.org Email agency@sendcaa.org



EMERGENCY ASSISTANCE APPLICATION
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
LIHEAP
SFN 62 (10-2006)

☐ Energy Share
☐ LIHEAP Emergency Assistance

Name		Social Security Number		County
Address	City	State	Zip Code	Telephone Number
Ages of All Household Members-List Applicant's Age First				
Emergency assistance is needed with what fuel? <input type="checkbox"/> Electricity <input type="checkbox"/> Propane <input type="checkbox"/> Natural Gas <input type="checkbox"/> Coal <input type="checkbox"/> Fuel Oil		Emergency assistance is needed other than fuel? <input type="checkbox"/> Minor Home Repair <input type="checkbox"/> Consumer Goods <input type="checkbox"/> Minor Furnace Repair <input type="checkbox"/> Non-Heat Electric Referral <input type="checkbox"/> Furnace Replacement <input type="checkbox"/> Self Reliance Referral		
Name of Company That Fuel is Purchased From	Name on Account		Account Number	
Dollar Amount of Emergency Assistance You Are Applying For		Dollar Amount You Paid on Energy Bills in the Last 6 Months		
List the reasons you are applying for Emergency Assistance (illness, car accident, loss of job, etc.)				
Did you discuss making regular monthly or weekly payments with your energy supplier/vendor? <input type="checkbox"/> Yes-What arrangements did you make? <input type="checkbox"/> No-Why Not?				
Have you tried to get a bank loan, family loan, or help from other agencies to pay on your bill? <input type="checkbox"/> Yes-Assistance From? <input type="checkbox"/> No-Why Not?				
Do you have a plan on how to avoid needing emergency assistance in the future? Explain. <input type="checkbox"/> Yes <input type="checkbox"/> No				

List the net income of each household member for application month		
Name of Person #1	Income This Month	Source
Name of Person #2	Income This Month	Source
Name of Person #3	Income This Month	Source
Name of Person #4	Income This Month	Source
Total Net Income for Household		

List Assets of Each Household Member
Amount For All Household Members in Checking
Amount For All Household Members in Savings
Amount For All Household Members in Other Accounts

Amount Spent This Month For:

Food - Total Cost	Less Food Stamps	Your Cost
Rent-Amount You Pay	Own Home-Mortgage	Tax Property (per month)
Homeowner's Insurance	Water	Electricity
Heat	Telephone (Land or Cell)	Other Utilities
Prescriptions Paid or Anticipated	Medical Bills	Medical Insurance Premium

Transportation Costs:

Gas or Other Transportation Costs	Vehicle Insurance (1 month)	Vehicle Payment (One Month)
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Employment Costs:

Day Care	Tools for Employment	Clothes for Employment
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Personal Care Costs

Other Mandatory Expenses (Explain)

Total Income	Total Expenses	Balance
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I certify that the information I have given is correct and complete to the best of my knowledge. I understand that benefits received based on false information must be repaid and could result in a fine, imprisonment, or both. I give my permission to LIHEAP and Energy Share to verify and share information affecting my eligibility and benefits and to my energy supplier to provide information regarding my account and energy consumption.

Signature	Date
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AGENCY USE ONLY

Local Action: <input type="checkbox"/> Denied <input type="checkbox"/> Approved or <input type="checkbox"/> Approved and Request State Approval	
CSSB (LIHEAP Representative)	Date

Emergency Assistance Payments

Date of Payment	Reason Code	Heat Type	Usage	Invoice/Account No.	Amount Requested	Amount Paid
Total Paid						

Does this bring applicant current? <input type="checkbox"/> Yes <input type="checkbox"/> No	Referred for Self Reliance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Referred for Energy Share? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has Plan of Action (SFN 11) been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No - Why Not?		List Other Agencies Referred To
Comments/Restrictions		

Household Demographic Form

Date		First Name		M.I.		Last Name	
Birthdate ____/____/____		Age		Social Security Number ____-____-____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		U.S Military <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> None Military		What is your Ethnicity? <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		How many in the Household?	
What is your primary race? <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"/> Unknown		What is your highest level of education? <input type="checkbox"/> 0-8 th <input type="checkbox"/> 9 th -12 th non-grad <input type="checkbox"/> HS grad/GED <input type="checkbox"/> 12 grade + some Post-Secondary <input type="checkbox"/> 2 or 4 years College Graduate <input type="checkbox"/> Graduate of other Post-Secondary		What is your medical coverage? <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Children's Health Insurance Program (CHIP) North Dakota Healthy Steps) <input type="checkbox"/> Military Health Care (Dept. of Defense, VA) <input type="checkbox"/> Direct Purchase (Health Exchange or ACA) <input type="checkbox"/> Employment Based (Insurance through employer) <input type="checkbox"/> None <input type="checkbox"/> Other			
What is your family type? <input type="checkbox"/> Single Person <input type="checkbox"/> Single Parent Female <input type="checkbox"/> Single Parent Male <input type="checkbox"/> Two Adults. No Children <input type="checkbox"/> Two Parent Household <input type="checkbox"/> Non-related Adults with Children <input type="checkbox"/> Multigenerational Household <input type="checkbox"/> Other: _____		What is your current housing situation? <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Other Permanent housing <input type="checkbox"/> Homeless <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Work Status? <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Unemployed(Short Term, 6 months or less) <input type="checkbox"/> Unemployed(Long Term, more than 6 months) <input type="checkbox"/> Unemployed (Not in Labor Force) <input type="checkbox"/> Retired			
Mailing Address			City		State ND		Zip Code
Primary Phone Number:			Secondary Phone Number:		Email Address:		
What income do you received?	How much?	How often?	What Benefits do you receive?		How much?	How often?	
<input type="checkbox"/> Employment	\$		<input type="checkbox"/> SNAP		\$		
<input type="checkbox"/> Social Security	\$		<input type="checkbox"/> WIC		\$		
<input type="checkbox"/> SSI	\$		<input type="checkbox"/> LIHEAP		\$		
<input type="checkbox"/> SSDI	\$		<input type="checkbox"/> Housing Choice Voucher (Section 8)		\$		
<input type="checkbox"/> VA Service-Connected	\$		<input type="checkbox"/> Public Housing		\$		
<input type="checkbox"/> VA Non-Service Connected	\$		<input type="checkbox"/> Permanent Supportive Housing		\$		
<input type="checkbox"/> Child Support	\$		<input type="checkbox"/> HUD-VASH		\$		
<input type="checkbox"/> Alimony / Spousal Support	\$		<input type="checkbox"/> Childcare Voucher		\$		
<input type="checkbox"/> TANF	\$		<input type="checkbox"/> Affordable Care Act Subsidy		\$		
<input type="checkbox"/> Worker's Compensation	\$		<input type="checkbox"/> Other: _____		\$		
<input type="checkbox"/> Unemployment	\$		<input type="checkbox"/> Unknown				
<input type="checkbox"/> Other: _____	\$		<input type="checkbox"/> I have no income at this time (initial here): _____				

You certify that the information you have disclosed is correct and complete to the best of your knowledge. You understand that failure to provide the needed documentation or knowingly providing false information will result in denial of assistance and your case will be closed due to fraud. All information provided will be kept in the strictest of confidence. You agree to sign this form at your own will. Your file may be monitored by state agencies for funding and quality review purposes

Applicant Signature: _____ **Date:** _____

Additional Household Members

First Name		MI	Last Name		Relationship to Head of Household
Birthdate ____/____/____		Age		Social Security Number ____-____-____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No			U.S Military <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> None Military		What is your Ethnicity? <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
What is your primary race? <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"/> Unknown			What is your highest level of education? <input type="checkbox"/> 0-8 th <input type="checkbox"/> 9 th -12 th non-grad <input type="checkbox"/> HS grad/GED <input type="checkbox"/> 12 grade + some Post-Secondary <input type="checkbox"/> 2 or 4 years College Graduate <input type="checkbox"/> Graduate of other Post-Secondary		What is your medical coverage? <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Military Health Care <input type="checkbox"/> Direct Purchase <input type="checkbox"/> Employment Based <input type="checkbox"/> Other
What income do you received?	How much?	How often?	What income do you received?	How much?	How often?
<input type="checkbox"/> Employment	\$	\$	<input type="checkbox"/> Alimony / Spousal Support	\$	\$
<input type="checkbox"/> Social Security	\$	\$	<input type="checkbox"/> TANF	\$	\$
<input type="checkbox"/> SSI	\$	\$	<input type="checkbox"/> Private Disability Insurance	\$	\$
<input type="checkbox"/> SSDI	\$	\$	<input type="checkbox"/> Pension / Retirement	\$	\$
<input type="checkbox"/> VA Service-Connected	\$	\$	<input type="checkbox"/> Worker's Compensation	\$	\$
<input type="checkbox"/> VA Non-Service Connected	\$	\$	<input type="checkbox"/> Unemployment	\$	\$
<input type="checkbox"/> Child Support	\$	\$	<input type="checkbox"/> Other: _____	\$	\$

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First Name		MI	Last Name		Relationship to Head of Household
Birthdate ____/____/____		Age		Social Security Number ____-____-____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No			U.S Military <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> None Military		What is your Ethnicity? <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
What is your primary race? <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"/> Unknown			What is your highest level of education? <input type="checkbox"/> 0-8 th <input type="checkbox"/> 9 th -12 th non-grad <input type="checkbox"/> HS grad/GED <input type="checkbox"/> 12 grade + some Post-Secondary <input type="checkbox"/> 2 or 4 years College Graduate <input type="checkbox"/> Graduate of other Post-Secondary		What is your medical coverage? <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Military Health Care <input type="checkbox"/> Direct Purchase <input type="checkbox"/> Employment Based <input type="checkbox"/> Other
What income do you received?	How much?	How often?	What income do you received?	How much?	How often?
<input type="checkbox"/> Employment	\$	\$	<input type="checkbox"/> Alimony / Spousal Support	\$	\$
<input type="checkbox"/> Social Security	\$	\$	<input type="checkbox"/> TANF	\$	\$
<input type="checkbox"/> SSI	\$	\$	<input type="checkbox"/> Private Disability Insurance	\$	\$
<input type="checkbox"/> SSDI	\$	\$	<input type="checkbox"/> Pension / Retirement	\$	\$
<input type="checkbox"/> VA Service-Connected	\$	\$	<input type="checkbox"/> Worker's Compensation	\$	\$
<input type="checkbox"/> VA Non-Service Connected	\$	\$	<input type="checkbox"/> Unemployment	\$	\$
<input type="checkbox"/> Child Support	\$	\$	<input type="checkbox"/> Other: _____	\$	\$

Additional Household Members

First Name		MI	Last Name		Relationship to Head of Household
Birthdate ____/____/____		Age		Social Security Number ____-____-____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No			U.S Military <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> None Military		What is your Ethnicity? <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
What is your primary race? <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"/> Unknown			What is your highest level of education? <input type="checkbox"/> 0-8 th <input type="checkbox"/> 9 th -12 th non-grad <input type="checkbox"/> HS grad/GED <input type="checkbox"/> 12 grade + some Post-Secondary <input type="checkbox"/> 2 or 4 years College Graduate <input type="checkbox"/> Graduate of other Post-Secondary		What is your medical coverage? <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Military Health Care <input type="checkbox"/> Direct Purchase <input type="checkbox"/> Employment Based <input type="checkbox"/> Other
What income do you received?	How much?	How often?	What income do you received?	How much?	How often?
<input type="checkbox"/> Employment	\$	\$	<input type="checkbox"/> Alimony / Spousal Support	\$	\$
<input type="checkbox"/> Social Security	\$	\$	<input type="checkbox"/> TANF	\$	\$
<input type="checkbox"/> SSI	\$	\$	<input type="checkbox"/> Private Disability Insurance	\$	\$
<input type="checkbox"/> SSDI	\$	\$	<input type="checkbox"/> Pension / Retirement	\$	\$
<input type="checkbox"/> VA Service-Connected	\$	\$	<input type="checkbox"/> Worker's Compensation	\$	\$
<input type="checkbox"/> VA Non-Service Connected	\$	\$	<input type="checkbox"/> Unemployment	\$	\$
<input type="checkbox"/> Child Support	\$	\$	<input type="checkbox"/> Other: _____	\$	\$

Additional Household Members

First Name		MI	Last Name		Relationship to Head of Household
Birthdate ____/____/____		Age		Social Security Number ____-____-____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No			U.S Military <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> None Military		What is your Ethnicity? <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
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What income do you received?	How much?	How often?	What income do you received?	How much?	How often?
<input type="checkbox"/> Employment	\$	\$	<input type="checkbox"/> Alimony / Spousal Support	\$	\$
<input type="checkbox"/> Social Security	\$	\$	<input type="checkbox"/> TANF	\$	\$
<input type="checkbox"/> SSI	\$	\$	<input type="checkbox"/> Private Disability Insurance	\$	\$
<input type="checkbox"/> SSDI	\$	\$	<input type="checkbox"/> Pension / Retirement	\$	\$
<input type="checkbox"/> VA Service-Connected	\$	\$	<input type="checkbox"/> Worker's Compensation	\$	\$
<input type="checkbox"/> VA Non-Service Connected	\$	\$	<input type="checkbox"/> Unemployment	\$	\$
<input type="checkbox"/> Child Support	\$	\$	<input type="checkbox"/> Other: _____	\$	\$

Self-Sufficiency Program Eligibility Questions

Do you receive Rental Assistance?	Yes: How much? \$ _____	No
Does your family receive Food Stamps?	Yes: How much? \$ _____	No
Does your family receive Fuel Assistance?	Yes: What is your heat source? <input type="checkbox"/> Oil <input type="checkbox"/> Natural Gas <input type="checkbox"/> Propane <input type="checkbox"/> Electric <input type="checkbox"/> Other	No
Do you have an Eviction notice?	Yes: How much owed? \$ _____	No
Do you have a Utility Shut Off notice?	Yes: How much owed? \$ _____	No
Rent/Mortgage Amount: \$ _____	Number of Bedrooms: _____	N/A

Please check the ONE that best describes your current living situation:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Emergency shelter | <input type="checkbox"/> Hotel | <input type="checkbox"/> Apartment you rent | <input type="checkbox"/> Place not meant to be lived in |
| <input type="checkbox"/> With friends / family | <input type="checkbox"/> Home you own | <input type="checkbox"/> County jail or prison | <input type="checkbox"/> Treatment Center |
| <input type="checkbox"/> Transitional housing | <input type="checkbox"/> Psychiatric hospital | <input type="checkbox"/> Other: _____ | |

How long have you been in the above living situation? _____

If less than 90 days, what is the zip code of the last place that you did stay more than 90 days? _____

What is your history of homelessness?

- | | |
|--|---|
| <input type="checkbox"/> Not homeless | <input type="checkbox"/> First time homeless AND less than one year without a home |
| <input type="checkbox"/> Multiple times homeless | <input type="checkbox"/> Long-term homeless: homeless for at least 1 year OR 4 times homeless in the past 3 years |

What type(s) of assistance are you looking for?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Rent Assistance | <input type="checkbox"/> Deposit Assistance | <input type="checkbox"/> Utility Assistance | <input type="checkbox"/> Education / Job Training |
| <input type="checkbox"/> Mortgage assistance | <input type="checkbox"/> Apartment Search | <input type="checkbox"/> Finance / Budget / Credit | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Child care assistance | <input type="checkbox"/> Other: _____ | | |

Please explain your need for emergency assistance in detail:

Client Action Plan

Some ideas for goals you can work on include:

- oGet stable housing oWork on education oPay off loans / credit debt
- oGet a job / 2nd job oStart a savings account oFind reliable childcare oStart an emergency fund
- oIncrease credit score oGet healthcare / insurance oBuy a car

Goal #1	Who Is Responsible	Follow Up Date	Follow Up Notes
Step #1:			
Step #2:			
Step #3:			
Goal #2	Who Is Responsible	Follow Up Date	Follow Up Notes
Step #1:			
Step #2:			
Step #3:			
Goal #3	Who Is Responsible	Follow Up Date	Follow Up Notes
Step #1:			
Step #2:			
Step #3:			
Applicant Printed Name		Applicant Signature	
Agency Staff Printed Name		Agency Staff Signature	Position:
			Date

Monthly Household Budget

Expenses				Income (use <u>NET</u> income)		
Expense Item		Monthly Amount	Past Due Amount	Income Source(s) <u>all</u> household members	Monthly Amount	
30% Shelter	Rent / Mortgage	\$	\$	Employment (applicant)	\$	
	Heating (fuel oil, gas)	\$	\$	Employment (co-applicant)	\$	
	Electricity	\$	\$	Self-Employment (applicant)	\$	
	Water, Sewer, Garbage	\$	\$	Self-Employment (co-applicant)	\$	
	Internet / Cable	\$	\$	Veteran's Benefits (applicant)	\$	
15% Food	Groceries – food ONLY	\$	\$	Veteran's Benefits (co-applicant)	\$	
	Lunches – school / work	\$	\$	Unemployment (applicant)	\$	
	Meals outside the home	\$	\$	Unemployment (co-applicant)	\$	
	Child care	\$	\$	Worker's Compensation (applicant)	\$	
	Child support	\$	\$	Worker's Compensation (co-applicant)	\$	
	Legal expenses (attorney, fines)	\$	\$	Short / Long-term Disability (applicant)	\$	
5% Clothing	Clothing – normal needs	\$	\$	Short / Long-term Disability (co-applicant)	\$	
	Uniforms – school or work	\$	\$	Child Support (applicant)	\$	
	Laundromat, dry cleaning, repair	\$	\$	Child Support (co-applicant)	\$	
5% Household	Household items & repairs	\$	\$	Alimony (applicant)	\$	
	Cell Phone / Telephone (land line)	\$	\$	Alimony (co-applicant)	\$	
	Cleaning supplies	\$	\$	SSDI / SSI / Social Security (applicant)	\$	
20% Transportation	Car payment	\$	\$	SSDI / SSI / Social Security (co-applicant)	\$	
	Car insurance	\$	\$	TANF (applicant or co-applicant)	\$	
	Car gas / maintenance / repairs	\$	\$	Food Stamps (applicant or co-applicant)	\$	
	Bus / cab fare	\$	\$	WIC Applicant? Y or N Co-applicant? Y or N	\$	
5% Health	Health insurance	\$	\$	Fuel Assistance Y or N oil gas propane electric	\$	
	Dental insurance	\$	\$	Retirement / Pension (applicant)	\$	
	Health / Dental / Rx co-pays	\$	\$	Retirement / Pension (co-applicant)	\$	
5% Insurance	Renter's / Homeowner's insurance	\$	\$	Child Care Assistance (applicant)	\$	
	Life insurance	\$	\$	Child Care Assistance (co-applicant)	\$	
	Retirement fund	\$	\$	Other: _____	\$	
5% Personal	Personal toiletries (hair/nail care, etc.)	\$	\$	Other: _____	\$	
	Recreation & Entertainment	\$	\$	Income TOTAL		
	School supplies	\$	\$	Loans / Credit Payments		
	Pet supplies	\$	\$	Bank / Company Name	Payment	Balance
5% Miscellaneous	Subscriptions (newspaper / magazines)	\$	\$		\$	\$
	Tobacco / alcohol	\$	\$		\$	\$
	Babysitter	\$	\$		\$	\$
	Gifts (holiday, birthday, etc.)	\$	\$		\$	\$
	Emergency Fund	\$	\$		\$	\$
	Savings	\$	\$		\$	\$
	Other: _____	\$	\$		\$	\$
	Other: _____	\$	\$		\$	\$
Expenses TOTAL		\$	\$	Loan / Credit Payment TOTAL		\$ _____ \$

Monthly Income: \$ _____
Monthly Expenses: - \$ _____
TOTAL \$ _____

Total Past Due / Owed: \$ _____
Savings Goal: \$ _____



Release of Information

Southeastern North Dakota Community Action Agency
3233 S. University Dr.
Fargo, ND 58104

Legal Last Name:	Legal First Name:	MI	Date of Birth
Other names used by applicant:			

By signing this form, I authorize the following record holder(s) to disclose the following specific confidential information about me:

Initial	Agency Name	Mutual Exchange Y or N	Initial	Agency Name	Mutual Exchange Y or N
	County Social Services	Y N		Landlord	Y N
	Food Pantry	Y N		Presentation Partners in Housing	
	Salvation Army	Y N		Utility Company	Y N
	Employer	Y N		St. Vincent DePaul Society	Y N
	Job Service	Y N		Other	Y N

The following information is requested: name, sex, marital status, sex/age of family members, race/ethnicity, veteran status, income verification, current housing status, services currently received, and unmet needs.

The information I have requested will be used for: (be specific)

	Coordination of Services	Y N		Legal Proceedings	Y N
	Obtaining Collateral Information	Y N		Referral	Y N
		Y N		Other	Y N

This Release of Information Consent Form will be in effect until _____ (not more than one year from today's date) or until termination of services.

Client Consent:

This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the agency or person. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium including, but not limited to oral, written, or electronic transmission.

You give permission to discuss my request for assistance with the selected agencies above. It is further agreed upon that information during the application process is shared with SENDCAA employees for determining if you are eligible for services. You release SENDCAA and any of its employees from any claims arising from this authorization and disclosure. .

SENDCAA employees are considered mandated reporters. SENDCAA follows the North Dakota Century Code Statute 50-25.1-03 on Child Abuse and Neglect and the North Dakota Century Code Statute 50-25.2-03 on Vulnerable Adult Protection.

Applicant Printed Name		Applicant Signature		Date
Authorized Representative Printed Name	Authorized Representative Signature	Relationship to Applicant	Date	
Agency Staff Printed Name	Agency Staff Signature	Position:	Date	

AUTHORIZATION TO DISCLOSE INFORMATION

PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose a social security number will not affect the disclosure of other information. This agency will not condition services on your agreement to authorize disclosure of your health information.

INSTRUCTIONS: Provide information as it existed when the service was provided.

First Name _____	Middle Name _____	Last Name _____	Social Security _____ - _____ - _____	Birthdate ____/____/____	M F Gender
Street Address _____		City _____	State ND	ZIP _____	County _____
1. I hereby authorize: Southeastern North Dakota Community Action Agency (SENDCAA) 3233 S. University Dr. Fargo, ND 58104					
2. To release information to: Administrators of the North Dakota Homeless Management Information System 1600 E. Century Ave., Suite 2 2105 Lee Avenue Bismarck, ND 58503 Bismarck, ND 58504					
3. The following information is requested: name, reporting agency, sex, marital status, sex/age of family members, race/ethnicity, veteran status, income status, current housing status, reason for homelessness, services currently received, and unmet needs.					
4. The information identified above will be used for: research and analysis and reporting to the Department of Housing and Urban Development, the US Congress, the North Dakota legislature, and communities on the statistics and needs of the homeless in North Dakota for the purpose of increasing funding for housing and services to the homeless. No personal identifying information will be released, except to the North Dakota HMIS.					
5. This authorization to disclose information remains in effect until _____ or 12 months or a specific event which could terminate the operation of the release of information _____.					
CLIENT CONSENT: This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the agency or person. Refer to the Privacy Notice for further description of revocation rights. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium including, but not limited to oral, written, or electronic transmission. I have been provided with a copy of the North Dakota HMIS Privacy Notice _____ (Client's Initials)					
Client Printed Name _____		Client Signature _____			Date _____
Authorized Representative Printed Name _____		Authorized Representative Signature _____		Relationship to Applicant _____	Date _____
Agency Staff Printed Name _____		Agency Staff Signature _____		Position: _____	Date _____
—	CHECK IF APPLICABLE – NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.				
NOTICE: Except for information subject to 42 CFR Part 2, information disclosed to another entity may potentially be re-disclosed, in which case it may not be protected by state or federal law.					
* I authorize the release of the indicated sensitive status(es) by my initials below: _____ Mental Health _____ HIV / AIDS _____ Chemical Dependency					



HUD Disclosure Statement / Conflict of Interest

The following Disclosure Statement / Conflict of Interest is for the purpose of providing information to program participants/clients accessing services from Southeastern North Dakota Community Action Agency (SENDCAA).

This is to give you, _____, notice that SENDCAA serves all counties within Region V (Cass, Ransom, Richland, Sargent, Steele, and Traill counties) and has a relationship with Region V Community Development Corporation (RVCDC). RVCDC also serves Grand Forks County with a single project in Northwood. RVCDC has a principal purpose of planning, developing, owning, and managing affordable housing projects in Southeastern ND. SENDCAA's Executive Director and a few of SENDCAA's Board of Directors are voting members of RVCDC. RVCDC has ownership of projects in Milnor (multifamily), Lisbon (multifamily), Hankinson (multifamily), Hatton (multifamily), Gwinner (2 elderly, 1 multifamily), Fairmount (multifamily), Casselton (multifamily), West Fargo (elderly), Fargo (special needs), and Northwood (multifamily). SENDCAA staff maintains the physical properties and maintains files for Section 42, HOME, Rural Development, HUD compliance. Compliance consists of annual review of tenant income, leases, and conducting Housing Quality Inspections on each of the rental properties.

To obtain housing counseling services from SENDCAA's Housing Counseling Program, you are not required to rent housing whereby RVCDC has a vested interest. In addition, you are not required to participate in any programs or services provided by SENDCAA in order to obtain or access housing counseling services. This includes but is not limited to the following programs and services: Food Pantry, Commodity Food Programs, Weatherization and Energy Conservation Program, Shelter Plus Care Program, Tri-State Help Program, HOME Rehabilitation Programs, Individual Development Accounts, Head Start, etc.

SENDCAA certifies that it shall abide by the conflict of interest provisions in 24 CFR 85.36 and OMB Circular A-110 for the procurement of property and services. If a person is an employee, agent, consultant, officer, elected official, or appointed official of a participating jurisdiction, state recipient or sub-recipient of Housing and Urban Development funds, and has related responsibilities or access to inside information, that person may not: obtain a financial benefit or interest from any activity for themselves or those with whom they have a family or business tie during their tenure or for one year thereafter.

I / we have read this Disclosure Statement / Conflict of Interest form and understand the information as provided by Southeastern North Dakota Community Action Agency (SENDCAA).

Participant Signature: _____ Date: _____

Case Manager Signature: _____ Date: _____

Staff Notes (continued):