### ANOKA COUNTY COMMUNITY ACTION PROGRAM, INC.

1201 89<sup>th</sup> Avenue NE | Suite 345 | Blaine, MN 55434 Phone: 763-783-4747 | Fax: 763-783-4700 Website: www.accap.org



# ACCAP Rental Assistance – Anoka County Client Application

Client Name:	Date:					
Amount of Past Due Rent:						
Self-attestation:						
I am past due on my rent as	a result of the COVID-19 pandemic and need financial assistance.					
Client Signature Phone number						
Current address						
(Please indicate with an "X"	cial assistance from any of the following agencies/organizations:  () Assistance? Yes No					
The Salvation Army? Yes_	No					
United Way 211/Housing Link? Yes No						
Consent to Exchange Information: I authorize Anoka County Community Action Program, Inc. to share information with the Property Owner/Landlord listed below and other governmental or social service agencies. This consent will be valid for a period of one year or the duration of the services applied for.						
Client Signature						
Please provide Anoka County Community Action Program with the following information:						
Name of Property Owner/Landlord						
Property Owner/Landlord Telephone Number						
Property Owner/Landlord Email						
Property Owner/Landlord Address						
	<del></del>					

This form is only for use during the COVID-19 Pandemic

**Date** 

**ACCAP Staff Signature** 

## Anoka County Community Action Program, Inc.



## **AGENCY INTAKE**

1201 89<sup>th</sup> Avenue NE Suite 345 Blaine, MN 55434

Phone: 763-783-4747 FAX: 763-783-4700

www.accap.org

This form asks for data about you and your family. If you decide not to complete this form, we may not be able to provide you with all helpful information and resources. If you complete this form, we will use the information to identify resources, provide you with information, coordinate services, and create summary data for evaluation and funding purposes. Only ACCAP Staff will use the data on this form. You must consent for ACCAP to share this information with any other agency

<u>Consent to Exchange Information</u>: I authorize Anoka County Community Action Program, Inc. to share this information with county, state and local welfare agencies, community based organizations, local, state, public and private human service and housing agencies, the MN Department of Jobs and Training, the United States Department of Labor, the United States Department of Health and Human Services, and State and local education programs. I agree to allow Anoka County to share information with ACCAP. This consent will be valid for a period of one year or the duration of the services for which you are applying (if service is longer than one year).

Signature of Head of Household	Date			
Signature of Household Member	Date			

Head of Household											
First Name		Last	Last Name			Date of Birth Social		Social S	Security Number		
Street Address		I				City			State	2	Zip
					-	Town	•				
Cov	<u> </u>	D.	ace			TOWI				Modica	   Insurance
Sex ☐ Male	│ │		ace :/African Ame	rican	☐ Ful	l Tim	<b>Employment</b> e <b>□</b> Part-Tir	no		es, Priva	
☐ Female			ican Indian	illaii			Work 🗖 Unemp	_		es, State	ie
Hispanic/			ic Islander		☐ Cor	_	· ·	•		-	
Latino	☐ Multi	•			☐ Ret			/			
☐ Yes ☐ No					☐ Oth	her		_			
Education	n .		Disabil	itv			Home Pho	ne		Second	ary Phone
☐ Non Grad		☐ None		-	<b>⊒</b> Men	ıtal	nome i ne		Secondary Phone		
☐ High School/(	GED		tive 🖵 Visua		⊒ Blind						
☐ Some College		☐ Speed			<b>⊒</b> Deaf					☐ Cell	☐ Work
2 or 4 Year De	egree	☐ Breatl	hing 🚨 Ortho	opedic [	☐ Othe	er					
Family Typ	pe		Language				Housing		S	pecial Ci	rcumstances
☐ Single Person		☐ Fnglis	h 🗖 Spanish 🛭	☐ Hmor	ng 🗆	<b>l</b> Owr	_			omestic	
☐ Single Parent,		_	h 🖵 Chinese		_	Rent	t		☐ Pr	egnant	Teen
☐ Single Parent,	/Male	☐ Vietna	amese 🖵 Japa	anese		<b>l</b> Buyi	ng			on-Pare	nt Caregiver
☐ Adults with C	hildren	☐ Korea	n 🗖 Hattian 🛭	<b>☐</b> Somal	li 🛮 🗆	<b>l</b> Hom	neless			eteran	
☐ Adults w/o Ch	nildren		C 🗖 Karen			<b>l</b> Tem	porarily Living wi	th Family		arenting	
			e American		Re	ent A	mount \$			_	nguage Learner
		☐ Camb		<b>¬</b>			<u> </u>		<b>□</b> T/	ANF/MF	P/DWP
		L Russia	an 🗖 Oromo (	<b>→</b> Nuer							
☐ Annuitios		Child Cupp	ort			ome	ds/Intorost	Пга	rnad I	ncomol	Magas
							ds/Interest ent				
							s Benefits				
. ,	Unemployment Benefits Other Total Amount \$  Family Household Member										
First Name			Last Name	allilly	iiouse		Social Security N	umher		Date o	f Rirth
Thist italine			Last Hame				Social Security IV	umber		Date	, Direit
D. L. C			1 1.1	I					1	/1	••
Relationsh	-			   □\\/b:	+ <u>^</u> □ [	Race			Hispanic/Latino □Yes □No		
· · ·			iite □ Black/African American ian □American Indian			Sex					
Other Relation			арагент			aiian/Pacific Islander 🗖 Multiracial			☐Male ☐Female		
	loyment		Madia	l Insura	•	1	Education		v	Disabi	
Full-Time	Part				nce	$\perp_{\Box}$		□Phy	cical		ntal  Cognitive
☐ Seeking Work			,						ıal		d □Speech
_	☐ Othe		□No			_			earing Deaf Breathing		
☐ Temporary						•					
			L	Spec	ial Cir		tances		•		
☐ Domestic Abu	use 🖵 Pro	egnant Te	en 🖵 Non-Pa	rent Car	egiver	U V6	eteran 🗖 Parentir	ng 🗖 Englis	sh Lan	guage L	earner
☐ TANF/MFIP/DWP											
Income											
						Dividends/Interest □Ea					
	☐ TANF/MFIP/DWP ☐Retire				ment 🗖 Self-Employed						
		SSI   SSDI   Veterans Benefits   Public Assistance									
☐ Unemployment Benefits ☐ Other ☐ Total Amount \$											
I .											

Family Household Momber									
Family Household Member  First Name Social Security Number Date of Birth						Date of Birth			
riistivanie	Last Name	st Name Social Security Number Date of Birt				Date of Birth			
Relationship to Head of Hou		D-	ice		⊔icr	 panic/Latino			
☐ Spouse ☐ Child ☐ Foster Child ☐	□White □ B			Yes □No					
☐ Adult Child ☐ Parent ☐ Grandpa		☐ Asian ☐ A	-			C			
□Other Relation □Not Related □Hawaiian/Pacific Islander □					cial	Sex □M	1ale □Female		
Employment	Medica	l Insurance	E	ducation		Disability			
☐ Full-Time ☐ Part-Time	☐Yes, Pri	vate	☐ Non (				cal  Mental  Cognitive		
☐ Seeking Work ☐ Unemployed	☐Yes, Sta	ite	☐ High	School/GED			_		
☐ Contract ☐ Other	□No		☐ Some		☐Hearing ☐Deaf ☐Breathing				
☐ Temporary ☐ Retired			□ 2 or 4	Year Degree	□Orthopedic □Other				
		Special Circ	umstanc	es					
☐ Domestic Abuse ☐ Pregnant Te	een 🗖 Non-Pa	rent Caregiver	☐ Vetera	n □ Parenting 〔	<b>☐</b> Englis	h Lan	guage Learner		
		Inco	ome						
☐ Annuities ☐ Child Supp	oort	Divi	idends/In	terest	🗖 Ear	ned Ir	ncome/Wages		
☐ No Income ☐ TANF/MF	IP/DWP	□Retirement □ S			🖵 Sel	elf-Employed			
□ SS □SSI	<b></b> SSDI	<b>□</b> Vet	terans Bei	nefits	<b>□</b> Pu	blic A	Assistance		
☐ Unemployment Benefits	☐ Unemployment Benefits ☐ Other ☐ Total Amount \$								
HAVE EACH ADULT MEMBER OF YOUR HOUSEHOLD SIGN A CONSENT STATEMENT (back page)									
Family Household Member									
First Name Last Name Social Security Number Date of Birth					Date of Birth				
Relationship to Head of Household Race Hispanic/Latino						panic/Latino			
☐ Spouse ☐ Child ☐ Foster Child ☐	□White □ B	Black/Afric	ican American		□Yes □No				
☐ Adult Child ☐ Parent ☐ Grandpa	☐ Asian ☐ A				Sex				
☐Other Relation ☐Not Related	☐Hawaiian/F	Pacific Isla	c Islander 🚨 Multiracial		☐Male ☐Female				
Employment Medical Insurance			Education			Disability			
☐ Full-Time ☐ Part-Time	☐Yes, Pri	vate 🔲 Non		Grad	□Physical □Mental □Cognitive				
☐ Seeking Work ☐ Unemployed	□Yes, Sta	ite	☐ High School/GED		□Visual □Blind □Speech				
☐ Contract ☐ Other	□No		☐ Some	me College		aring 🗖 Deaf 🗖 Breathing			
☐ Temporary ☐ Retired		☐ 2 or 4 Year Degree ☐ Orthopedic ☐ Other			ic <b>O</b> ther				
Special Circumstances									
☐ Domestic Abuse ☐ Pregnant Te	en 🗖 Non-Pa	rent Caregiver	☐ Vetera	n 🗖 Parenting 🛭	☐ Englis	h Lan	guage Learner		
☐ TANF/MFIP/DWP									

**HAVE EACH ADULT MEMBER OF YOUR HOUSEHOLD SIGN A CONSENT STATEMENT (back page)** 

Income

 □ Annuities
 □ Child Support
 □ Dividends/Interest
 □ Earned Income/Wages

 □ No Income
 □ TANF/MFIP/DWP
 □ Retirement
 □ Self-Employed

 □ SS
 □ SSI
 □ Veterans Benefits
 □ Public Assistance

☐ Unemployment Benefits ☐ Other ☐ Total Amount \$\_\_\_\_\_

#### **HAVE EACH ADULT MEMBER OF YOUR HOUSEHOLD SIGN A CONSENT STATEMENT**

Consent to Exchange Information: I authorize Anoka County Community Action Program, Inc. to share this

Client Signature	Date
information with county, state and local welfar private human service and housing agencies Department of Labor, the United States Depart programs. I agree to allow Anoka County to sha	ze Anoka County Community Action Program, Inc. to share this re agencies, community based organizations, local, state, public and s, the MN Department of Jobs and Training, the United States tment of Health and Human Services, and State and local education are information with ACCAP. This consent will be valid for a period of the you are applying (if service is longer than one year).
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