

ANOKA COUNTY COMMUNITY ACTION PROGRAM, INC.

1201 89th 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:		
<u>Self-attestation:</u> 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 _____ Have you applied for financial assistance from any of the following agencies/organizations: (Please indicate with an "X") Anoka County Emergency Assistance? Yes___ No___ The Salvation Army? Yes___ No___ United Way 211/Housing Link? Yes___ No___ <u>Consent to Exchange Information:</u> 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 _____ _____		

ACCAP Staff Signature

Date

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

Anoka County Community Action Program, Inc.



AGENCY INTAKE

1201 89th Avenue NE Suite 345
Blaine, MN 55434

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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

Consent to Exchange Information: 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 Name	Date of Birth	Social Security Number	
Street Address		City	State	Zip
		Town		
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multiracial	Employment <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seeking Work <input type="checkbox"/> Unemployed <input type="checkbox"/> Contract <input type="checkbox"/> Temporary <input type="checkbox"/> Retired <input type="checkbox"/> Other _____	Medical Insurance <input type="checkbox"/> Yes, Private <input type="checkbox"/> Yes, State <input type="checkbox"/> No	
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No				
Education <input type="checkbox"/> Non Grad <input type="checkbox"/> High School/GED <input type="checkbox"/> Some College <input type="checkbox"/> 2 or 4 Year Degree	Disability <input type="checkbox"/> None <input type="checkbox"/> Physical <input type="checkbox"/> Mental <input type="checkbox"/> Cognitive <input type="checkbox"/> Visual <input type="checkbox"/> Blind <input type="checkbox"/> Speech <input type="checkbox"/> Hearing <input type="checkbox"/> Deaf <input type="checkbox"/> Breathing <input type="checkbox"/> Orthopedic <input type="checkbox"/> Other	Home Phone <input type="checkbox"/> Cell <input type="checkbox"/> Work	Secondary Phone <input type="checkbox"/> Cell <input type="checkbox"/> Work	
Family Type <input type="checkbox"/> Single Person <input type="checkbox"/> Single Parent/Female <input type="checkbox"/> Single Parent/Male <input type="checkbox"/> Adults with Children <input type="checkbox"/> Adults w/o Children	Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Hmong <input type="checkbox"/> French <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Hattian <input type="checkbox"/> Somali <input type="checkbox"/> Arabic <input type="checkbox"/> Karen <input type="checkbox"/> Native American <input type="checkbox"/> Cambodian <input type="checkbox"/> Russian <input type="checkbox"/> Oromo <input type="checkbox"/> Nuer	Housing <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Buying <input type="checkbox"/> Homeless <input type="checkbox"/> Temporarily Living with Family Rent Amount \$ _____	Special Circumstances <input type="checkbox"/> Domestic Abuse <input type="checkbox"/> Pregnant Teen <input type="checkbox"/> Non-Parent Caregiver <input type="checkbox"/> Veteran <input type="checkbox"/> Parenting <input type="checkbox"/> English Language Learner <input type="checkbox"/> TANF/MFIP/DWP	
Income				
<input type="checkbox"/> Annuities _____ <input type="checkbox"/> Child Support _____ <input type="checkbox"/> Dividends/Interest _____ <input type="checkbox"/> Earned Income/Wages _____ <input type="checkbox"/> No Income <input type="checkbox"/> TANF/MFIP/DWP _____ <input type="checkbox"/> Retirement _____ <input type="checkbox"/> Self-Employed _____ <input type="checkbox"/> SS _____ <input type="checkbox"/> SSI _____ <input type="checkbox"/> SSDI _____ <input type="checkbox"/> Veterans Benefits _____ <input type="checkbox"/> Public Assistance _____ <input type="checkbox"/> Unemployment Benefits _____ <input type="checkbox"/> Other _____ Total Amount \$ _____				

Family Household Member				
First Name	Last Name	Social Security Number	Date of Birth	
Relationship to Head of Household <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Foster Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Adult Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relation <input type="checkbox"/> Not Related		Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multiracial	Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		
Employment <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seeking Work <input type="checkbox"/> Unemployed <input type="checkbox"/> Contract <input type="checkbox"/> Other <input type="checkbox"/> Temporary <input type="checkbox"/> Retired	Medical Insurance <input type="checkbox"/> Yes, Private <input type="checkbox"/> Yes, State <input type="checkbox"/> No	Education <input type="checkbox"/> Non Grad <input type="checkbox"/> High School/GED <input type="checkbox"/> Some College <input type="checkbox"/> 2 or 4 Year Degree	Disability <input type="checkbox"/> Physical <input type="checkbox"/> Mental <input type="checkbox"/> Cognitive <input type="checkbox"/> Visual <input type="checkbox"/> Blind <input type="checkbox"/> Speech <input type="checkbox"/> Hearing <input type="checkbox"/> Deaf <input type="checkbox"/> Breathing <input type="checkbox"/> Orthopedic <input type="checkbox"/> Other	
Special Circumstances				
<input type="checkbox"/> Domestic Abuse <input type="checkbox"/> Pregnant Teen <input type="checkbox"/> Non-Parent Caregiver <input type="checkbox"/> Veteran <input type="checkbox"/> Parenting <input type="checkbox"/> English Language Learner <input type="checkbox"/> TANF/MFIP/DWP				
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Employment <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seeking Work <input type="checkbox"/> Unemployed <input type="checkbox"/> Contract <input type="checkbox"/> Other <input type="checkbox"/> Temporary <input type="checkbox"/> Retired	Medical Insurance <input type="checkbox"/> Yes, Private <input type="checkbox"/> Yes, State <input type="checkbox"/> No	Education <input type="checkbox"/> Non Grad <input type="checkbox"/> High School/GED <input type="checkbox"/> Some College <input type="checkbox"/> 2 or 4 Year Degree	Disability <input type="checkbox"/> Physical <input type="checkbox"/> Mental <input type="checkbox"/> Cognitive <input type="checkbox"/> Visual <input type="checkbox"/> Blind <input type="checkbox"/> Speech <input type="checkbox"/> Hearing <input type="checkbox"/> Deaf <input type="checkbox"/> Breathing <input type="checkbox"/> Orthopedic <input type="checkbox"/> Other
Special Circumstances <input type="checkbox"/> Domestic Abuse <input type="checkbox"/> Pregnant Teen <input type="checkbox"/> Non-Parent Caregiver <input type="checkbox"/> Veteran <input type="checkbox"/> Parenting <input type="checkbox"/> English Language Learner <input type="checkbox"/> TANF/MFIP/DWP			
Income <input type="checkbox"/> Annuities_____ <input type="checkbox"/> Child Support_____ <input type="checkbox"/> Dividends/Interest_____ <input type="checkbox"/> Earned Income/Wages_____ <input type="checkbox"/> No Income <input type="checkbox"/> TANF/MFIP/DWP_____ <input type="checkbox"/> Retirement_____ <input type="checkbox"/> Self-Employed_____ <input type="checkbox"/> SS_____ <input type="checkbox"/> SSI_____ <input type="checkbox"/> SSDI_____ <input type="checkbox"/> Veterans Benefits_____ <input type="checkbox"/> Public Assistance_____ <input type="checkbox"/> Unemployment Benefits_____ <input type="checkbox"/> 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
Relationship to Head of Household <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Foster Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Adult Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relation <input type="checkbox"/> Not Related		Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multiracial	Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Employment <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seeking Work <input type="checkbox"/> Unemployed <input type="checkbox"/> Contract <input type="checkbox"/> Other <input type="checkbox"/> Temporary <input type="checkbox"/> Retired	Medical Insurance <input type="checkbox"/> Yes, Private <input type="checkbox"/> Yes, State <input type="checkbox"/> No	Education <input type="checkbox"/> Non Grad <input type="checkbox"/> High School/GED <input type="checkbox"/> Some College <input type="checkbox"/> 2 or 4 Year Degree	Disability <input type="checkbox"/> Physical <input type="checkbox"/> Mental <input type="checkbox"/> Cognitive <input type="checkbox"/> Visual <input type="checkbox"/> Blind <input type="checkbox"/> Speech <input type="checkbox"/> Hearing <input type="checkbox"/> Deaf <input type="checkbox"/> Breathing <input type="checkbox"/> Orthopedic <input type="checkbox"/> Other
Special Circumstances <input type="checkbox"/> Domestic Abuse <input type="checkbox"/> Pregnant Teen <input type="checkbox"/> Non-Parent Caregiver <input type="checkbox"/> Veteran <input type="checkbox"/> Parenting <input type="checkbox"/> English Language Learner <input type="checkbox"/> TANF/MFIP/DWP			
Income <input type="checkbox"/> Annuities_____ <input type="checkbox"/> Child Support_____ <input type="checkbox"/> Dividends/Interest_____ <input type="checkbox"/> Earned Income/Wages_____ <input type="checkbox"/> No Income <input type="checkbox"/> TANF/MFIP/DWP_____ <input type="checkbox"/> Retirement_____ <input type="checkbox"/> Self-Employed_____ <input type="checkbox"/> SS_____ <input type="checkbox"/> SSI_____ <input type="checkbox"/> SSDI_____ <input type="checkbox"/> Veterans Benefits_____ <input type="checkbox"/> Public Assistance_____ <input type="checkbox"/> Unemployment Benefits_____ <input type="checkbox"/> Other_____ Total Amount \$ _____			

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Client Signature _____ Date _____

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