Helping People. Changing Lives.
community Action
PARTNERSHIP
NORTHEAST MISSOURI
Adair • Clark • Knox • Schuyler • Scotland

COMMUNITY SERVICES APPLICATION

When applying for Community Services **fill all sheets out completely and sign where indicated**. If there is NO income of any kind in the household, the Zero Income Form will also need to be completed for everyone over the age of 18.

Return this packet along with the following:

☐ Proof of ALL income for the past 30 days
(current SS award letter or bank statement showing current deposit, pay stubs, etc.)

☐ Copy of Social Security cards for everyone in the home

☐ Copy of Photo ID for everyone in the home over 18 years old

☐ Copy of past due notice you need assistance paying (if applicable)
(copy of current lease for rental assistance)

Questions contact us at:

Community Action Partnership of Northeast Missouri
215 N Elson Kirksville, MO 63501
Phone: 660-665-9855 - Fax: 660-665-5542
Website: www.capnemo.org

DISCLAIMER

Completing this application does not guarantee that you will receive services from CAPNEMO.
All eligibility criteria must be met for you to qualify for and receive assistance.
Each Program under CAPNEMO has their own set of eligibility criteria.
Referrals to these programs will determine eligibility.

CAPNEMO COMMUNITY SERVICES APPLICATION

Physical Address: _____

City, State, Zip: _____

Phone Number: _____ Alternate Number: _____ May We Text You? Yes or No

Email: _____May We Email You? Yes or No

What is your living status?

☐ Rent ☐ Own ☐ Unhoused/Shelter ☐ Living with others

Name (First, Middle, Last)	SSN	DOB	M/F	Relation	Marital Status	Race	Highest Education Level Completed
Example: Jane Doe	*000-00-0000*	*00/00/00*	*F*	*self*	*M*	*C*	*GED*
1)				Self			
2)							
3)							
4)							
5)							
6)							
7)							
8)							
9)							

Is anyone in the home a veteran? ☐ Yes ☐ No If So Whom_____

Is anyone in the home have medical insurance? ☐ Yes ☐ No If So Whom and what

type: _____

Household Income

Please list ALL sources of income for ALL household members

Household Member's Name	Source of Income*	Amount of Income	How Often Received

*Wages; Self-Employment; Pensions; Social Security; SSI; Child Support; TANF, Other

Is any person in the household ordered to RECEIVE child support? **Child Support Case Number:**

☐ Yes ☐ No If yes, how much? _____ _____

If No, would you like a Child Support Referral? ☐ Yes ☐ No

Non-Cash Benefits

Is any person in the household RECEIVE any of these benefits?

☐ SNAP ☐ WIC ☐ HUD ☐ Child Care Subsidy ☐ Other _____

Is there any other information you would like us to know?

_____

_____

_____

CAPNEMO Assessment

1. How would you describe your family's current housing situation?

☐ No Subsidy; Own or Rent
☐ Subsidized (*HUD, Section 8, Low-Income Housing*)
☐ Living with friends or relatives
☐ At risk of homelessness (eviction notice/temporary)
☐ Homeless

2. What is your family's current household income and how would you rate your money management practice?

☐ Able to pay all bills and save
☐ Sufficient income to pay bills without subsidies
☐ Income meets most financial obligations (may include subsidies)
☐ Some income; budget includes subsidies
☐ No income; no budget

3. How would you describe your family's current employment situation, including status, skill set, benefits, and how it meets basic needs?

☐ Full-time employment above minimum wage
☐ Full-time employment with minimum wage
☐ Part-time employment
☐ Unemployed with skill and/or previous work history
☐ Unemployed with no skill and/or previous work history

4. How would you describe your family's mode of transportation?

☐ Public or private transportation always available
☐ Public or private transportation available most of the time
☐ Public or private transportation available some of the time
☐ Public or private transportation rarely available
☐ No transportation available

CAPNEMO Assessment

5. How would you describe your family's current physical and oral health situation, including insurance and ability to pay for medications?

☐ No physical health problems
☐ Does not interfere with goals
☐ Occasionally interfere with employment or other goals
☐ Regularly interfere with goals
☐ Prohibit goals

6. Are mental health and/or substance abuse issues present in the family, and if so, how are they being addressed?

☐ No mental health problems
☐ Does not interfere with goals
☐ Occasionally interferes with goals
☐ Regularly interferes with goals
☐ Prohibits goals

7. How would you describe your family's regular food, nutrition, and clothing situation?

☐ Able to afford food without food programs
☐ Able to afford some food without food programs
☐ Unable to afford food without food program assistance; SNAP (food stamps), WIC etc.
☐ Unable to afford food without food program assistance; food bank
☐ Unable to afford or obtain food

8. How would you describe your academic skill set and how it impacts employment or other goal attainment?

☐ Master's / Doctorate
☐ 2- or 4-year degree or certification
☐ Some college tech training
☐ High School/Hi Set (GED)
☐ Did not graduate High School

CAPNEMO COMMUNITY SERVICES APPLICATION

CLIENT CONFIDENTIALITY AGREEMENT / RELEASE OF INFORMATION

I certify that the information given on this application is true and accurate to the best of my knowledge and belief. I understand that such information is subject to verification, and I further realize that falsified or fraudulent information may result in the rejection of this application.

Under the terms of this Agreement, CLIENT agrees to release to CAPNEMO information that is confidential and proprietary to CLIENT (Confidential Information), to be used solely for the Agency's related statistics, services, and programs. Confidential Information refers to any and all information of a confidential, proprietary, or secret nature which is, or may be, related in any way to the family, medical records, job history, present or future, or CLIENT, or any related data. Confidential Information includes, for example, but not limited to spouses or other family members, ages, salaries, financial standings, criminal records, medical records, and all other pertaining to the family information. CAPNEMO will consider all information received from CLIENT to be strictly confidential, as required by the Privacy Act, and subject to the restrictions of this Agreement; except for information that is (i) generally known to the public, (ii) in the possession of CAPNEMO before receipt from CLIENT, (iii) obtained later by the Agency from a third party without restriction or violation of Agreements.

CAPNEMO will not disclose CLIENT's confidential information to any other party without the prior written consent of CLIENT, CAPNEMO may, however, disclose Confidential Information to its employees and/or programs within the agency, but only if the employee has a legitimate need to know, and has agreed to terms similar to those in this Agreement. The Community Action Agency may also disclose this Confidential Information (i) to medical personnel in an emergency; (ii) to qualified personnel for research, audits, or program evaluation, as long a CLIENT identity is not identified; (iii) to a third party based on court orders; and (iv) to appropriate authorities in cases of suspected child abuse or neglect. CAPNEMO will be responsible for any use or disclosure of Confidential Information by any of its employees, or agents to third parties who should not share this information.

This agreement may be amended only in writing and shall be governed by the laws of the State of Missouri.

Please sign below to indicate that you have read this Consent and agree with its terms.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

MISSOURI COMMUNITY ACTION MANAGEMENT INFORMATION SYSTEM

Client Consent – Release of Information

The Missouri Community Action Management Information System (MIS) serves Missouri's Community Action Agencies, a network of partner agencies working together to provide service to low-income individuals and families in Missouri.

The information that is collected in the (MIS) database is protected by limiting access to the database and by limiting with whom the information may be shared, in compliance with the standards set forth in the Health Insurance Portability and Accountability Act (HIPAA). Every person and agency that is authorized to read or enter information into the databases has signed an agreement to maintain the security and confidentiality of the information. Any person or agency that is found to violate their agreement may have their access rights terminated and may be subject to further penalties.

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:

I authorize partner agencies and their representatives to share the following information regarding my family/household and me. I understand this information is for the purpose of assessing our needs for employment, housing, utility assistance, food, counseling and/or other services.

The information may consist of the following:

- My financial situation, to include the amount of my income, and savings of money and/or food stamps I may have.
- This information may also include debts I owe for utilities, rent, etc.
- Identifying and/or historical information regarding myself and members of my family/household.

I UNDERSTAND THAT:

- Information I give concerning physical or mental health problems will not be shared with other partner agencies in any way that identifies me.
- The partner agencies have signed agreements to treat my information in a professional and confidential manner. I have the right to view the client confidentiality policies used by the MIS.
- Staff members of partner agencies who will see my information have signed agreements to maintain confidentiality regarding my information.
- I have the right to request information about who has accessed my information.
- The partner agencies may share non-identifying information about the people they serve with other parties working to end poverty.
- The release of my information for MIS does not guarantee that I will receive assistance, and my refusal to authorize the use of my identifying information does not disqualify me from receiving assistance.
- This authorization will remain in effect unless I revoke it in writing, and I may revoke authorization at any time by signing a written statement available at any partner agency.
- If I revoke my authorization all identifying information already in the database will remain, but will no longer be shared with partner agencies.

Partner Agencies: A list of the partner agencies within the Statewide Community Action Network may be viewed prior to signing this form.

_____ _____ _____

Client Name (please print) Client Signature Date

_____

Social Security Number

_____ _____

Staff Signature Date

CAPNEMO SERVICES INFORMATION / REFERRALS

I would like more information on the following programs or referrals:

☐ HUD Housing Application ☐ Child Care Subsidy information ☐ Energy Assistance (LIHEAP)

☐ Skill-Up (education/career building) ☐ SNAP Application ☐ Needing Household Items

☐ Weatherization ☐ Needing Hygiene Products

☐ Needing Clothing ☐ Early Head Start/Head Start Programs

☐ Future Community Leaders Program (youth life skills)

Any other items needing help with that are not listed above:

_____

_____

_____ _____

Client Signature Date