Payment Assistance
Intake Packet

Please complete Page 1 and 2 of application

Assistance Needed: (Please check)

- ☐ Rent
- ☐ Security Deposit
- ☐ Utility
- ☐ Gas Card/LATS
- ☐ Auto Assistance

Please Attach the Following:

- ☐ Proof of **ALL** Household Income
- ☐ Copy of Bill or Statement from Landlord (Everything but Gas Card)
- ☐ Proof of Employment or Interview (Gas Card only)
- ☐ Department of Social Services Denial Letter
- ☐ Completed Budget Sheet
- ☐ Completed Release Sheet

Please complete and mail/fax back all required documents to:

Catholic Charities of Livingston County
34 East State Street
Mount Morris, NY 14510
Fax: (585) 658-2513

CSBG Application & Funding Eligibility

#_____

GENERAL INFORMATION: **DATE:** _____

Date of Birth: _____ **SS#** _____ (Required)

Last Name _____ **First Name** _____ **M.I.** _____

If you have been known by other names, please provide: _____

Street Address _____

Mailing Address _____
(if different from street address, ex: PO Box)

City _____ **State** _____ **Zip Code** _____ **County** _____

Primary Phone (_____) _____ - _____ ☐ Cell ☐ Home **Secondary Phone?** (_____) _____ - _____ ☐ Cell ☐ Home

E-mail Address: _____

Are you a US Citizen? Yes _____ No _____ If not, are you authorized to work in the United States Yes _____ No_____
Explain, please _____

DEMOGRAPHICS: **(Required Information** for Grant Reporting and program eligibility)

Gender? ☐ Male ☐ Female ☐ Other _____

Are you a Veteran? ☐ Yes ☐ No If "yes", Dates of Active Service ____/____/____ to ____/____/____

Do you have health insurance? ☐ Yes ☐ No **IF "Yes" what type...**

☐ Medicaid ☐ Medicare ☐ Military Coverage ☐ Direct Purchase
☐ Employer Based ☐ State Children Heath Coverage ☐ State Health Insurance for Adults

Do you have a disability? ☐ Yes ☐ No

Family Type: ☐ Single ☐ Female Single Parent ☐ Male Single Parent ☐ Multi-Generational Household
☐ Two Adults, No Children ☐ Two Parent Household ☐ Non-related Adults w/Children

Source and Level of Family Income:

Size of Family: _____ (including yourself) (***Definition of Family***: Individuals living together as one economic unit)

Housing: ☐ Own ☐ Rent ☐ Other permanent housing ☐ Homeless ☐ Other_____

Employment Status:

☐ Employed Full-time ☐ Employed Part-Time ☐ Seasonal Farm Worker ☐ Retired
☐ Unemployed (6 month or less) ☐ Unemployed (more than 6 months) ☐ Unemployed (never held job)

Other Source(s) of Income:

☐ TANF ☐ EITC ☐ SSI ☐ SSDI ☐ Pension ☐ Private Disability
☐ Unemployment Insurance ☐ Child Support ☐ SS Retirement ☐ Alimony ☐ Other_____
☐ Workers Comp ☐ VA Service Connected Disability ☐ VA Non-Service Connected Disability Pension

Non Cash Benefits Received:

☐ SNAP/Food Stamps ☐ WIC ☐ LIHEAP ☐ Housing Choice Voucher
☐ Public Housing ☐ Permanent Supportive Housing ☐ HUD-VASH ☐ Childcare Voucher
☐ Affordable Care Act Subsidy ☐ Other_____

Household Income Level: Please **circle** the range of the yearly income level of your household below.

	Annual Income		Annual Income		Annual Income
1	$0 - $14,000	4	$25,001 - $30,000	7	$40,001 - $46,000
2	$14,001 - $20,000	5	$30,001 - $35,000	8	$46,001 - $51,000
3	$20,001 - $25,000	6	$35,001 - $40,000	9	Over $51,000

ETHNICITY:

☐ White (not Hispanic) ☐ Black or African American ☐ Hispanic or Latino ☐ Alaskan / American Indian

☐ Asian (not Hispanic) ☐ Hawaiian/Pacific Islander ☐ Other _____

EDUCATION: (Check highest level completed)

☐ Drop-out, highest grade completed _____ ☐ High School Diploma ☐ GED

☐ IEP Diploma ☐ Some College ☐ Vocational Degree ☐ Certificate in _____

☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctoral Degree

If you obtained a degree past high school, what was your major? _____

CERTIFICATION:

- I, (Print Name)_____, affirm that the statements and information I have provided in this training application, including any attached papers, are true to the best of my knowledge under penalties of perjury. I understand that any misrepresentations may result in my disqualification for training/funding or my removal from the training program.
- If I am terminated as a result of falsifying information on this application, I understand I may also be prosecuted for fraud and/or be required to reimburse any money spent. My signature serves as giving my permission to verify any and all information contained in this assessment.
- **I also acknowledge that I may be asked to provide additional information or supporting documentation to determine eligibility for funding for this training program.**

YOU MUST SIGN! **Signed:** _____ **Date:** _____

For Office Use Only

Additional Needs:

☐ Emergency Shelter ☐ Emergency Payments ☐ Medical Care ☐ Employment Services ☐ Other_____

Referrals:

☐ Chances & Changes ☐ Geneseo Parish Outreach ☐ Liv. Co. Workforce Development ☐ Noyes Hospital ☐ Catholic Charities

Catholic Charities
Livingston County

Initials: _____ **Filled:** _____ **Packet R or E** _____

Today's Date: _____ **Referred by:** _____

First Name: _____ **MI:** ____ **Last Name:** _____

Address: _____
Street **City** **State** **Zip** **County**

Primary Phone: (_____) _____-_____

Veteran: Yes No **Domestic Violence:** Yes No **Substance Abuse:** Yes No

Disabled: Yes No **Mental Health:** Yes No

Housing Status: __ **Stable Housing** ___**At Risk of Loss of Housing** ___**Homeless, if Homeless, how long?** _____

Assistance Needed: (check all that apply)

__Personal Hygiene Items
__Diapers
__Food
__Housing/Homeless
__Transitional Jail Services
__Youth Mentoring
__Parenting
__Home and Community Based Services
__Rent, Security Deposit, Utility Pmt
__SSI/SSDI Case Management
__Bus/Gasoline for Employment
__Employment Services
__Transportation-(Elderly/Disabled)
__Children's Health Home Care Management
__Budgeting Assistance

__**Furniture (Please list what is needed):** _____

List all household members (including yourself)

First Name & MI	Last Name	Gender	Relationship	Date of Birth	Social Security #	Education Level	Race	Ethnicity (Circle One)
								Hispanic Non-Hispanic
								Hispanic Non-Hispanic
								Hispanic Non-Hispanic
								Hispanic Non-Hispanic
								Hispanic Non-Hispanic
								Hispanic Non-Hispanic

Monthly Household Income for all members in Household:

Earned Income $_____
SSI/SSDI $_____
Public Assistance $_____
Child Support $_____
Unemployment $_____
Alimony or other Spousal Support $_____
Other $_____

Non Cash Benefits: (check all that apply)

SNAP (food stamps) ____ WIC____ Section 8 or Public Housing____

Health Insurance: **Yes** **No**

Medicaid: **Yes** **No** If yes, which option: Excellus MVP Fidelis United Health

Medicare: **Yes** **No**

I certify that all the information is true to the best of my knowledge. By signing this form, I give Catholic Charities of Livingston County permission to review this information with other agencies and vendors. I also give permission to verify my medical insurance status, and does not guarantee me assistance.

Signature: _____

34 East State Street, Mount Morris, New York 14510 Phone: (585) 658-4466 Fax: (585) 658-2513

Catholic Charities
Livingston County

CONSENT TO RELEASE AND/OR RECEIVE INFORMATION

I, _____ do hereby give my consent for
(client name)
Catholic Charities of Livingston County Emergency Payment Services to release and/or request information in order to coordinate care services between Emergency Payment Services and community resources, landlords and/or billing companies to disclose and/or obtain from each other the following information:

(Check all services applicable)

- ☐ Salvation Army
- ☐ Local Area Churches
- ☐ Department of Social Services
- ☐ Landlord (please list landlord name) _____
- ☐ Utility Company (please state company name) _____
- ☐ Insurance Company (please state company name) _____
- ☐ Local gas station
- ☐ Other Catholic Charities Service Providers
- ☐ Local Food Pantry
- ☐ Other:_____

_____

I authorize Catholic Charities of Livingston County to disclose information as indicated in order to coordinate care. I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically as described below.

_____
Signature of Client

_____
Signature of Witness

_____
Signature of Parent, Guardian, or Authorized Representative (when required)

Date:_____
Expires 1 year from date or with discontinuation of services

The receiving agency should understand that this information is confidential and cannot be shared or re-released without the expressed permission of this agency/counselor and/or client.

Catholic Charities
Livingston County
Help that works.
Hope that lasts.

Monthly Budget Sheet

1. Your Monthly Income	
Take-home Pay (wages and tips)	
Additional Income (Side Business, interest, spouse pay, etc.)	
Total Income	

2. Your Monthly Expenses	
Rent or Mortgage	
Utilities (Gas, water, electric, insurance)	
Car (payment and insurance)	
Transportation expense (gas, tolls)	
Cable and Internet	
Cell Phone	
Other Subscription (Hulu, Netflix, Gym, etc.)	
Groceries	
Daycare	
Medical (Co-pays, prescriptions, etc.)	
Debt Payments (Credit Cards, Student Loans, etc)	
Dining, travel and enterainment	
Pet Expenses (Pet food, etc.)	
Personal Care and household (shampoo, dish soap, etc.)	
Other discretionary spending (hobbies etc.)	
Savings	
Other-child support	
Total Expenses	

3. Your Bottom Line	
Income minus expenses	