



Helping people. Improving lives.

| OFFICE USE ONLY |
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ASSISTANCE APPLICATION

| HEAD OF HOUSEHOLD | | | |
|--|--|---|-----------------------------------|
| DATE: | NAME (Last, First, Middle): | DATE OF BIRTH: | |
| STREET ADDRESS: | | CITY: | STATE: ZIPCODE: |
| HOME PHONE: | CELL PHONE: | MARITAL STATUS: | |
| SOCIAL SECURITY #: | LICENSE/ID #: | STATE: | EDUCATION (Last Grade Completed): |
| SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | VETERAN: <input type="checkbox"/> YES <input type="checkbox"/> NO | DISABLED: <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| ETHNICITY: <input type="checkbox"/> HISPANIC / LATINO <input type="checkbox"/> NON-HISPANIC / LATINO <input type="checkbox"/> DON'T KNOW | | | |
| RACE: <input type="checkbox"/> AMERICAN INDIAN OR ALASKAN NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> PACIFIC ISLANDER <input type="checkbox"/> WHITE <input type="checkbox"/> DON'T KNOW | | | |
| HEALTH INSURANCE PROVIDER: <input type="checkbox"/> NONE <input type="checkbox"/> EMPLOYER <input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> OTHER _____ | | | |
| DO YOU RECEIVE HUD, SECTION 8 HOUSING OR ANY OTHER HOUSING ASSISTANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES HOW MUCH DOES THE PROGRAM PAY TOWARDS YOUR RENT _____ | | | |
| ARE YOU CURRENTLY EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO EMPLOYER _____ PHONE _____ | | | |
| PRIOR LIVING SITUATION: (Where did you stay last night?) <input type="checkbox"/> Room / Apartment / House that you rent <input type="checkbox"/> Room / Apartment / House that you own <input type="checkbox"/> Staying with a family member or friend <input type="checkbox"/> Foster care or group home <input type="checkbox"/> Jail / Prison / Juvenile Detention Facility <input type="checkbox"/> Place not meant for habitation (car, street, abandoned building) <input type="checkbox"/> Shelter including hotel or motel with a voucher <input type="checkbox"/> Hotel or Motel without a voucher <input type="checkbox"/> Transitional housing for homeless persons <input type="checkbox"/> Permanent housing for formerly homeless <input type="checkbox"/> Psychiatric hospital or facility <input type="checkbox"/> Substance abuse treatment facility <input type="checkbox"/> Hospital (non psychiatric) <input type="checkbox"/> Other _____ <input type="checkbox"/> Don't know | | LENGTH OF STAY AT PRIOR LIVING SITUATION: <input type="checkbox"/> One week or less <input type="checkbox"/> More than a week but less than a month <input type="checkbox"/> One to three months <input type="checkbox"/> More than three months but less than a year <input type="checkbox"/> One year or longer <input type="checkbox"/> Don't know HOUSING STATUS: <input type="checkbox"/> Literally Homeless <input type="checkbox"/> Imminently losing housing <input type="checkbox"/> Unstably housed and at risk of losing housing <input type="checkbox"/> Stably housed PRIOR ZIP CODE: (Last stable residence of at least 90 days) _____ | |
| INCOME SOURCES AND AMOUNTS FOR THE LAST 30 DAYS: | | AMOUNT | NON-CASH BENEFITS |
| | | | AMOUNT |

| | | | |
|---|----------|---|----------|
| <input type="checkbox"/> Alimony / Spousal Support | \$ _____ | <input type="checkbox"/> Children's health insurance program (CHIP) | \$ _____ |
| <input type="checkbox"/> Child support | \$ _____ | <input type="checkbox"/> Food stamps | \$ _____ |
| <input type="checkbox"/> General assistance (GA) | \$ _____ | <input type="checkbox"/> LIHEAP | \$ _____ |
| <input type="checkbox"/> Pension from a former job | \$ _____ | <input type="checkbox"/> Other TANF funded service | \$ _____ |
| <input type="checkbox"/> Private disability insurance | \$ _____ | <input type="checkbox"/> Section 8 utility allowance | \$ _____ |
| <input type="checkbox"/> Retirement income from social security | \$ _____ | <input type="checkbox"/> Section 8 public housing | \$ _____ |
| <input type="checkbox"/> Salary / Wages | \$ _____ | <input type="checkbox"/> TANF child care services | \$ _____ |
| <input type="checkbox"/> Social security disability income (SSDI) | \$ _____ | <input type="checkbox"/> TANF transportation services | \$ _____ |
| <input type="checkbox"/> TANF | \$ _____ | <input type="checkbox"/> Veteran's admin medical services | \$ _____ |
| <input type="checkbox"/> Unemployment insurance | \$ _____ | <input type="checkbox"/> WIC | \$ _____ |
| <input type="checkbox"/> Veteran's disability payment | \$ _____ | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Veteran's pension | \$ _____ | | |
| <input type="checkbox"/> Worker's compensation | \$ _____ | | |
| <input type="checkbox"/> Other _____ | | | |

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|--|---------------|--|---------------|
| MONTHLY EXPENSES: | AMOUNT | MONTHLY EXPENSES: | AMOUNT |
| <input type="checkbox"/> Rent / Mortgage | \$ _____ | <input type="checkbox"/> Loan Payments | \$ _____ |
| <input type="checkbox"/> Water | \$ _____ | <input type="checkbox"/> Cable TV / Satellite / Internet | \$ _____ |
| <input type="checkbox"/> Gas | \$ _____ | <input type="checkbox"/> Credit Cards | \$ _____ |
| <input type="checkbox"/> Electric | \$ _____ | <input type="checkbox"/> Car Payment | \$ _____ |
| <input type="checkbox"/> Sanitation | \$ _____ | <input type="checkbox"/> Car Insurance | \$ _____ |
| <input type="checkbox"/> Home Phone | \$ _____ | <input type="checkbox"/> Other _____ | \$ _____ |
| <input type="checkbox"/> Cell Phone | \$ _____ | | |

| OTHERS IN HOUSEHOLD | | | | | |
|---------------------|---------------|-------------------|--------------|----------------|---------------|
| NAME | DATE OF BIRTH | SOCIAL SECURITY # | RELATIONSHIP | MONTHLY INCOME | INCOME SOURCE |
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REASON YOU ARE HERE TODAY:

I acknowledge that the above information is true and accurate and realize that any false information is fraud and could result in loss of pending or future services.

By my signature, I authorize Mountain Mission, Inc. and its staff to release and or obtain any information that may be necessary to process my case to determine the approval or denial of the help that was requested by me.

I also release Mountain Mission, Inc. and its staff of any and all liability resulting in the release or the obtaining of information, and I understand that I am waving my right to privacy by signing this application and release.

Applicant Signature _____ Date _____