Miami Valley Community Action Partnership
Emergency Services - CSBG Customer Intake Application

Have you already received a 3-day or eviction notice from your landlord? ☐Yes ☐ No	**Application Date** Month/Day/Year

Primary Applicant

First Name:	**Middle Name**	**Last Name**
Social Security Number:	**Date of Birth**	**Gender**
	Month/Day/Year	☐ Female ☐ Male ☐ Other
Disabled ☐Yes ☐ No	**Veteran** ☐Yes ☐ No	**SNAP (Food Stamps)** ☐Yes ☐ No

Current Residential Address

Street Address:			
Street Address Line 2:			
City:	State:	Zip Code:	County:
Phone Number:		Email Address: example@example.com	

Race	**Education**	**Ethnicity**
☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown/Not Reported ☐ Other:	☐ 0-8 ☐ 9-12 (Non Grad) ☐ HS Grad/GED ☐12 + Post-Secondary ☐ 2-4 Yr. Grad College	☐ Hispanic, Latino or Spanish Origins ☐ Not Hispanic, Latino or Spanish Origins

Household Information – Fill In Additional Household Members After Next Page

# In Household (including yourself)	**Family Type**	**Work Status**	**Health Insurance Type**	**Source of Income**
	☐ Single Parent/Female ☐ Single Parent/Male ☐ Two-Parent Household ☐ Single Person ☐ Two Adults/No Children ☐ Non-related Adults with children ☐ Multigenerational Household ☐ Other:	☐ Employed full-time ☐ Employed part-time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (short-term, 6 months or less) ☐ Unemployed (long-term, more than 6 months) ☐ Unemployed (not in labor force) ☐ Furloughed ☐ Retired ☐ Unknown/not reported ☐ Youth ages 14-24 who are neither working nor in school ☐ Other:	☐ Medicaid ☐ Medicare ☐ Private/Employment ☐ Self-Insured/Direct Pay ☐ None ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults ☐ Other:	☐ Employment ☐ Unemployment ☐ Self-Employment ☐ No Income ☐ Social Security ☐ TANF/ADC ☐ SSI/SSD ☐ Pension ☐ Disability ☐ Child Support ☐ Other (please specify):

Housing Status

☐ Own
☐ Rent
☐ Other Permanent
☐ Housing
☐ Homeless
☐ Other:

Income Period	**Income Amount**
☐ Weekly ☐ Bi-Weekly ☐ Bi-Monthly ☐ Monthly	

Please provide us with some additional information regarding your need for Emergency Services assistance. (Check all that apply)

☐ I contracted Covid-19 and I am unable to work.
☐ Covid-19 has impacted my place of employment. (I lost my job or my hours/salary have been reduced.)
☐ I currently have health issues that prevent me from working
☐ A natural disaster has effected my employment or ability to work.
☐ Other (Provide brief description):

Is one or more of your emergencies COVID-19 Related? If so, select which areas have been impacted. (Check all that apply)

☐ Childcare
☐ Dependent Child
☐ Eldercare
☐ Employment
☐ Housing
☐ Other (Provide brief description):

Please provide us with any additional details about your emergency situation that can help our Intake Specialists complete your application.

(Provide brief description):

Additional Household Members (Do Not Fill Out For Yourself)		
First Name	**Middle Name**	**Last Name**
Social Security Number	**Date of Birth**	**Gender**
	Month/Day/Year	☐ Female ☐ Male ☐ Other
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Disabled ☐Yes ☐ No	**Veteran** ☐Yes ☐ No	**Relationship** (e.g. daughter, son, spouse, etc.)
Health Insurance Type	**Source of Income**	
☐ Medicaid ☐ Medicare ☐ Private/Employment ☐ Self-Insured/Direct Pay ☐ None ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults ☐ Other:	☐ Employment ☐ Unemployment ☐ Self-Employment ☐ No Income ☐ Social Security ☐ TANF/ADC ☐ SSI/SSD ☐ Pension ☐ Disability ☐ Child Support ☐ Other (please specify):	
Income Period		**Income Amount**
☐ Weekly ☐ Bi-Weekly ☐ Bi-Monthly ☐ Monthly		

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Authorization for Information Exchange

By signing this authorization, I grant permission for the sharing of information which is to be used to determine eligibility for participation in the Community Services Block Grant (CSBG) or other agency programs under the umbrella of Community Action as operated by the Miami Valley Community Action Partnership for either myself or my family members.

I understand this release will terminate one year from the date I sign this authorization or sooner if I request so in writing.

I understand that all information obtained in association with this release will be held in strict confidence by the recipient.

I further direct that information shared resulting from my signature not be further disclosed without my specific written authorization.

I further declare that I understand and permit an information exchange strictly for disclosure purposes related to Miami Valley Community Action Partnership programming.

I also hereby give permission to release to and /or secure information from the following organizations for the purpose of securing services I have requested:

List Organizations:

_____

_____

_____

_____

_____

_____

I certify that this statement is true and correct to the best of my knowledge, and I authorize the release of any or all information necessary for verification purposes.

Applicant Signature: _____ Date: _____