



# Our Community Cares

Supporting Residents In Need  
In Columbia County NY

## Assistance Application

1. Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ Suffix \_\_\_\_\_

2. Nickname/Alias \_\_\_\_\_ 3. Maiden Name \_\_\_\_\_

4. Social Security Number \_\_\_\_\_ 5. Date of Birth \_\_\_\_\_ 6. Age \_\_\_\_\_

7. Place of Birth (City, State, Country) \_\_\_\_\_ 8. Gender: Male\_\_\_\_ Female\_\_\_\_

9. Phone Number(s) \_\_\_\_\_ 10. Email \_\_\_\_\_

### 11. Current or Most Recent Mailing Address

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

(a) Are you currently staying there? Yes \_\_\_\_\_ No \_\_\_\_\_ (b) How long at this address? \_\_\_\_\_

12. (a) Have you ever received services under another name? Yes \_\_\_\_ No \_\_\_\_

If yes, what name? \_\_\_\_\_

(b) Have you ever received services with another Social Security Number? Yes \_\_\_\_ No \_\_\_\_

If yes, what number? \_\_\_\_\_

13. Have you ever been convicted of a felony? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what year was the conviction? \_\_\_\_\_

If yes, what was the felony you were convicted of? \_\_\_\_\_

14. Have you or your spouse ever served in the US Military? Yes \_\_\_\_ No \_\_\_\_ If yes, what branch? \_\_\_\_\_

15. Please check what services you are interested in. (Check all that apply):

Available Services and/or referrals (Place an X)	
<input type="checkbox"/> Transitional Housing	<input type="checkbox"/> Grief Counseling
<input type="checkbox"/> Rental Assistance	<input type="checkbox"/> Fundraising
<input type="checkbox"/> Utility Assistance	<input type="checkbox"/> Emergency Clothing
<input type="checkbox"/> Emergency Food	<input type="checkbox"/> Professional Services
<input type="checkbox"/> Emergency Transportation	<input type="checkbox"/> Food / Meal Services for sick/elderly
<input type="checkbox"/> Employment/Job Training	<input type="checkbox"/> Information & Referral
<input type="checkbox"/> Benefit Assistance	<input type="checkbox"/> Other

16. Who referred you to Our Community Cares? (Place an X)

<input type="checkbox"/> Friend	<input type="checkbox"/> Law Enforcement/Police	<input type="checkbox"/> Web/Internet
<input type="checkbox"/> Family Member	<input type="checkbox"/> Shelter	<input type="checkbox"/> Self
<input type="checkbox"/> Hospital (non-psychiatric)	<input type="checkbox"/> VA	<input type="checkbox"/> Other Please explain
<input type="checkbox"/> Psychiatric hospital/facility	<input type="checkbox"/> Church/Religious Organization	_____
<input type="checkbox"/> Criminal Justice system	<input type="checkbox"/> Residential Program	_____



17. Are you (and your dependent children) capable of self-care? Yes\_\_\_\_ No\_\_\_\_ Yes with assistance\_\_\_\_

18. Do you or your spouse have a Disabling Condition? Yes\_\_\_\_ No\_\_\_\_

This means: Do you have a physical, mental, emotional, developmental disability, HIV/AIDS, diagnosable substance abuse problem, or chronic health condition of expected long duration that substantially limits your ability to live on your own?

19. Disability Type Check all that apply. Indicate if it is expected to be of long duration & if client is currently receiving services for this condition. (Place Y or N)

	Long Term Y/N	Currently receiving services for this condition Y/N		Long Term Y/N	Currently receiving services for this condition Y/N
Mental Illness			Physical Disability		
Alcohol Abuse			Developmental Disability		
Drug Abuse			Chronic Health Condition		
HIV/AIDS and related diseases			Other (please specify)		

Note: Chronic health condition - a diagnosed condition that is more than three months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples include but are not limited to: heart disease, severe asthma; diabetes; arthritis-related conditions; adult onset cognitive impairments (including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive related conditions); severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.

20. Household Configuration: Single\_\_\_\_ Family with Children\_\_\_\_ Family without Children\_\_\_\_ Other\_\_\_\_

20a. Are you the Head of Household? Yes\_\_\_\_ No\_\_\_\_

20b. How many children in your household? \_\_\_\_\_

20c. What is your total household size? \_\_\_\_\_

21. Please list information about all persons in your household. (attach a separate sheet if necessary)

Name (Last, First Middle)	Birth Date	Gender	Disability/ Special Needs
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	



***HOUSING INFORMATION***

Does the client Own\_\_\_\_\_ Rent\_\_\_\_\_

Housing Type? House\_\_\_\_\_ Apartment\_\_\_\_\_ Trailer\_\_\_\_\_ Duplex\_\_\_\_\_ Room\_\_\_\_\_

Rent or Mortgage Payment \$\_\_\_\_\_ Payment Frequency Monthly\_\_\_\_\_ Weekly\_\_\_\_\_

***TRANSPORTATION***

What is the client's mode of transportation?

Self car     Friend/family car     Public transportation     Walking     Other\_\_\_\_\_

**22. If this application is being made because of a fire or car accident, please answer the following questions:**

**22a: Did you own or rent the property / vehicle that was damaged?** Own\_\_\_\_\_ Rent\_\_\_\_\_

**22b: Were you at fault for the fire or the accident?** Yes\_\_\_\_\_ No\_\_\_\_\_

**22c: Were you insured?** Yes\_\_\_\_\_ No\_\_\_\_\_

**22d: If you were insured, do you have a deductible?** Yes\_\_\_\_\_ No\_\_\_\_\_ If yes, what is the amount?\_\_\_\_\_

**22e: If you were insured, please estimate the percentage of your loss you expect to be covered?** \_\_\_\_\_ %

**All questions on the application must be answered before your application will be accepted. All completed applications will be reviewed and voted on by the OCC Board of Directors. Majority vote rules. The Board of Directors' decision shall be final. The board reserves the right to accept or reject any application, based on their sole judgement, for any reason that it deems appropriate. You will be notified if your application is approved or rejected. If approved, you will be asked to sign an OCC Partnership Agreement that will list the specifics services OCC agrees to assist you with and the conditions you must abide by in order to receive services.**

**I have read and understand all of the information that has been provided for me. I also certify that all the information that I provided on this application is true and correct.**

\_\_\_\_\_  
**Signature of Applicant**

\_\_\_\_\_  
**Date**



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## Assistance Application

Please provide a personal statement about why this help would be beneficial to you or improve your life or the life of a loved one if it is approved.

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Printed Name

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Signature

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Date