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)

_____Transitional Housing	_____Grief Counseling
_____Rental Assistance	_____Fundraising
_____Utility Assistance	_____Emergency Clothing
_____Emergency Food	_____Professional Services
_____Emergency Transportation	_____Food / Meal Services for sick/elderly
_____Employment/Job Training	_____Information & Referral
_____Benefit Assistance	_____Other

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

____Friend	____Law Enforcement/Police	____Web/Internet
____Family Member	____Shelter	____Self
____Hospital (non-psychiatric)	____VA	____Other Please explain
____Psychiatric hospital/facility	____Church/Religious Organization	_____
____Criminal Justice system	____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 specifiy)		

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
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	

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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**

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.

_____

Printed Name

_____ _____

Signature Date