



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

- | | |
|---|--|
| <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?

- | | | |
|--|--|---|
| <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.

	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



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