

## **Disaster Relief Fund Assistance Application Large Scale**

Dear Prospective Recipient:

We welcome your application to this program which, if approved, aids individuals who have been the victim of a natural or man-made disaster to assist with related expenses. The amount of financial assistance that available is based upon available disaster relief funding. Applications are usually reviewed within 10-14 business days.

Please ensure all required documentation accompanies this application when it is returned to CCNKS. Lack of documentation may result in a delay in the processing of the application.

Required Documentation Includes the following:

- Application, completed in full*
- Proof of Income*
- Copies of Any Bills/Items to be Paid with the Funds (if applicable)*
- Documentation Related to Proof of the Disaster*

If you have difficulty completing the form or gathering any of the documents listed above, please contact the office. Exceptions can be made. Please return the completed application, with accompanying documentation to any of the Catholic Charities 3 locations.

**THANK YOU!**



**Disaster Relief Fund Assistance Application  
Large Scale**

**Please provide background information regarding disaster:**

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**How will you use these funds if approved?**

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**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Interviewer Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**REMEMBER TO INCLUDE PROOF OF ALL HOUSEHOLD INCOME AND ALL DOCUMENTATION  
RELATED TO THE ASSISTANCE YOU ARE REQUESTING**

**OFFICE USE ONLY:**

**Initials of Staff Receiving Application:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **AM / PM**

\_\_\_\_\_ **Proof of Income (130% Poverty Level)**

\_\_\_\_\_ **Documentation of Illness**

\_\_\_\_\_ **Documentation of Expenses to be Paid**

\_\_\_\_\_ **Agency Intake Form**

\_\_\_\_\_ **Completed Application**

\_\_\_\_\_ **Completed Budget Form**

**Staff Notes:**

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**For Case Manager Only:**

**Applicant Review Notes:**

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**Approval Date:** \_\_\_\_\_ **Amount Approved:** \_\_\_\_\_

**Denial Date:** \_\_\_\_\_ **Date Client Notified:** \_\_\_\_\_

**CCNKS - STABILIZATION & OUTREACH SERVICES**

**PROGRAM APPLICATION BUDGET FORM - MUST ACCOMPANY APPLICATION**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ DATE: \_\_\_\_\_

**INCOME SOURCES & AMOUNTS FOR LAST 30 DAYS**

<input type="checkbox"/> Earned Income	\$ _____	<input type="checkbox"/> General Assistance	\$ _____
<input type="checkbox"/> Unemployment Insurance	\$ _____	<input type="checkbox"/> Retirement Income from Social Security	\$ _____
<input type="checkbox"/> Supplemental Security Income (SSI)	\$ _____	<input type="checkbox"/> VA Non-Service Connected Disability	\$ _____
<input type="checkbox"/> Social Security Disability Income (SSDI)	\$ _____	<input type="checkbox"/> Pension from a Former Job	\$ _____
<input type="checkbox"/> VA Service Connected Disability Compensation	\$ _____	<input type="checkbox"/> Child Support	\$ _____
<input type="checkbox"/> Private Disability Insurance	\$ _____	<input type="checkbox"/> Alimony or other Spousal Support	\$ _____
<input type="checkbox"/> Worker's Compensation	\$ _____	<input type="checkbox"/> Other	\$ _____
<input type="checkbox"/> Temporary Assistance to Needy Families (TANF)	\$ _____	<b>TOTAL</b>	\$ _____

**NON -CASH BENEFITS AND AMOUNTS CURRENTLY RECEIVING** Please check box even if amount is unknown.

<input type="checkbox"/> SNAP/Food Stamps or money for food on a benefits card	\$ _____
<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	\$ _____
<input type="checkbox"/> TANF Child Care Services/Transportation Services/Other TANF Services	\$ _____
<input type="checkbox"/> Section 8, Public Housing, or Other Rental Assistance	\$ _____
<input type="checkbox"/> Other Source	\$ _____
<input type="checkbox"/> Temporary Rental Assistance	\$ _____
<input type="checkbox"/> Child Support	\$ _____
<b>TOTAL</b>	\$ _____

**EXPENDITURE TYPES AND AMOUNTS FOR LAST 30 DAYS**

<input type="checkbox"/> Rent/Mortgage	\$ _____	<input type="checkbox"/> Car Payment	\$ _____
<input type="checkbox"/> Electricity-Utility	\$ _____	<input type="checkbox"/> Gasoline (Vehicle)	\$ _____
<input type="checkbox"/> Gas/Heating Oil - Utility	\$ _____	<input type="checkbox"/> Insurance (Vehicle)	\$ _____
<input type="checkbox"/> Sewage/Trash	\$ _____	<input type="checkbox"/> Child Care (Personally Paid)	\$ _____
<input type="checkbox"/> Telephone-Home	\$ _____	<input type="checkbox"/> Health Insurance (Personally Paid)	\$ _____
<input type="checkbox"/> Cell Phone	\$ _____	<input type="checkbox"/> Withholding Tax	\$ _____
<input type="checkbox"/> Water -Utility	\$ _____	<input type="checkbox"/> Fines/Tickets/Restitution Payments	\$ _____
<input type="checkbox"/> Food (Excluding Food Stamps)	\$ _____	<input type="checkbox"/> Other _____	\$ _____
<input type="checkbox"/> Medical (Dr. Copays/Prescriptions)	\$ _____	<input type="checkbox"/> Other _____	\$ _____
<input type="checkbox"/> Transportation (Bus Passes/Cabs/Uber)	\$ _____	<input type="checkbox"/> Other _____	\$ _____
<b>TOTAL</b>			\$ _____

**TOTAL HOUSEHOLD INCOME AND NET INCOME**

Household Income \$ \_\_\_\_\_ Net Income \$ \_\_\_\_\_

**REASON FOR ASSISTANCE (Please only check the primary reason for requesting assistance)**

<input type="checkbox"/> Not Working/Seeking Work	<input type="checkbox"/> Medical-Short/Long Term	<input type="checkbox"/> Caring for Sick/Disabled Family	<input type="checkbox"/> Fire
<input type="checkbox"/> Sudden Job Loss	<input type="checkbox"/> Eviction - Non-Payment	<input type="checkbox"/> Weather/Natural Disaster	<input type="checkbox"/> Crime Victim
<input type="checkbox"/> Release from Incarceration	<input type="checkbox"/> Property Condemned	<input type="checkbox"/> Unexpected Expense (non-medical)	<input type="checkbox"/> Homelessness
<input type="checkbox"/> Non-Livable Wage	<input type="checkbox"/> Moving/Newly Relocated	<input type="checkbox"/> Family Disruption	<input type="checkbox"/> Other

**OUTSIDE FUNDS USED BY APPLICANT**

<input type="checkbox"/> LIEAP	<input type="checkbox"/> Salvation Army	<input type="checkbox"/> Red Cross
<input type="checkbox"/> Local Social Service Agency	<input type="checkbox"/> Local Food Bank	<input type="checkbox"/> Church _____
<input type="checkbox"/> Project Deserve - Gas	<input type="checkbox"/> Women Helping Women (Salina Only)	<input type="checkbox"/> Direct Prescription Assistance
<input type="checkbox"/> Share The Warmth	<input type="checkbox"/> Other: _____	

RELEASE OF INFORMATION: I verify that the information I have provided above is true and correct. I consent to the release of pertinent information contained the spaces above to CCNKS as necessary to determine my eligibility and provide services applied for.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_