Disaster Relief Fund Assistance Application
Small 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. Applications are usually reviewed within 10-14 business days. The limit for fund requests is **$200**.

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.

The completion of this form does not guarantee approval for assistance. You will be notified directly of the committee's decision.

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!

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Date of Application: _____

Type of Disaster: _____ **Date of Disaster:** _____

Applicant Name: _____
First **Middle Initial** **Last**

Date of Birth: _____ **Gender: Male/Female**

Address at time of Disaster: _____ **County:** _____

City: _____ **State:** _____ **Zip Code:** _____

Is this residence: Single Family Dwelling _____ **Apartment** _____ **Mobile Home** _____ **Other** _____

Do you: Rent this residence _____ **Name & Phone of Landlord** _____

Own this residence _____ **Name of Mortgage holder** _____

Current Living Situation: Pre-Disaster Home _____ **Family**____ **Friends**_____ **Temp. Housing** _____

Best Contact Phone Number: _____ **Cell** **Home** **Work** **Message Only**

Annual gross family income: _____ **Source of Income** _____
(Be sure to include child support, spousal maintenance, social security, disability, and all employment)

Number of persons in applicant's household: _____

Do you have homeowners or rental insurance? (Circle) Yes / No

Was housing subsidized by? **HUD/Sect 8:** _____ **HUD/FHA**_____ **Other:** _____

Did you share housing expenses? ___**No** ___**Yes** **Is this your primary residence?** ___**No** ___**Yes**

Please provide background information regarding disaster:

_____

_____

_____

_____

How will you use these funds if approved?

_____

_____

_____

Applicant Signature: _____ Date: _____

Interviewer Signature: _____ Date: _____

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

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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:

_____

_____

_____

_____

_____

For Case Manager Only:

Applicant Review Notes:

_____

_____

_____

_____

_____

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

□ Earned Income	$_____	□ General Assistance	$_____
□ Unemployment Insurance	$_____	□ Retirement Income from Social Security	$_____
□ Supplemental Security Income (SSI)	$_____	□ VA Non-Service Connected Disability	$_____
□ Social Security Disability Income (SSDI)	$_____	□ Pension from a Former Job	$_____
□ VA Service Connected Disability Compensation	$_____	□ Child Support	$_____
□ Private Disability Insurance	$_____	□ Alimony or other Spousal Support	$_____
□ Worker's Compensation	$_____	□ Other	$_____
□ Temporary Assistance to Needy Families (TANF)	$_____	**TOTAL**	**$**_____

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

□ SNAP/Food Stamps or money for food on a benefits card	$_____
□ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	$_____
□ TANF Child Care Services/Transportation Services/Other TANF Services	$_____
□ Section 8, Public Housing, or Other Rental Assistance	$_____
□ Other Source	$_____
□ Temporary Rental Assistance	$_____
□ Child Support	$_____
TOTAL	**$**_____

EXPENDITURE TYPES AND AMOUNTS FOR LAST 30 DAYS

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

TOTAL HOUSEHOLD INCOME AND NET INCOME

Household Income $ _____ Net Income $ _____

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

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

OUTSIDE FUNDS USED BY APPLICANT

□ LIEAP	□ Salvation Army	□ Red Cross
□ Local Social Service Agency	□ Local Food Bank	□ Church _____
□ Project Deserve - Gas	□ Women Helping Women (Salina Only)	□ Direct Prescription Assistance
□ Share The Warmth	□ 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: _____

CMH 11/2021