



# Cornerstone

Community Action Agency

## Intake Application

**Mail:**

114 Needham  
Coleman, TX 76834

(P) 325-625-4167

(F) 325-625-3335

mail@ctoinc.org

**Head of Household** (Office use only) **Received Date** \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ M \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Rent \_\_\_\_\_ Own \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Alternate Contact Name and phone No. \_\_\_\_\_

**Address Information**

Residential Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

County of Residence \_\_\_\_\_ Single Family Dwelling \_\_\_\_\_ Mobile home \_\_\_\_\_

**Sources of Household Income (Check all that apply)**

**Income Source:**

- Employment
- NO Income

**Other income:**

- VA
- SSI
- SSDI
- Pension
- Child Support
- Unemployment
- TANF

**Non Cash Benefits:**

- SNAP
- WIC
- Section 8
- LIHEAP
- HUD

**Veteran Information**

Are you, or anyone in the household a Veteran, Surviving Spouse of a Veteran, or a Dependent of Veteran? YES | NO

If yes, please identify which household member and circle the category that describes them.

Household Member \_\_\_\_\_ Veteran | Surviving Spouse | Dependent of Veteran

**Additional Information for Household members (Circle all that apply)**

Is anyone 60 years of age or older? YES | NO  
 Is anyone in the household disabled? YES | NO  
 Are there any children 5 years or younger? YES | NO

Is anyone living in your household age 14-24 that is not going to school or working? YES | NO  
 Have you ever received services from Cornerstone or CCAA in the past? YES | NO

**Documents Needed**

**2023 Income: Last 30 days**

Employment Checks  
 2023 Social Security/SSI Award Letter  
 Benefit Letter- VA, Child Support, TANF,  
 Unemployment, etc.

**ID Documents:**

Birth Certificates- All Members  
 ID/DL- Adults 18 & Over  
 SS Card- All Members  
 DD214- If you are a Veteran

**Current Utility Bills**

Electric  
 Gas  
 Propane  
 Water



# NEEDS ASSESSMENT

Please indicate what needs you have below by circling either "yes" or "no" in each box. If you circle "yes", please explain the need so that we can assess how to better serve you.

SERVICE	NEED	Client Explain	SERVICE	NEED	Client Explain
<b>Basic Needs:</b> Food, Clothing, foodstamps, WIC, Meals on Wheels, emergency, other	Yes  No		<b>Counseling:</b> Family, Alcohol/Substance Abuse, other	Yes  No	
<b>Income:</b> SSD, TANF, SS,SSI, VA, Child Support, budget, other	Yes  No		<b>Transportation:</b> to work, Drs. appointment, other	Yes  No	
<b>Employment:</b> Looking for a job, job search assistance, resume, other	Yes  No		<b>Veteran's Needs:</b> Home Repair Utility help Rent /Mortgage Dental Transpiration repair/ fuel	Yes  No	
<b>Utility Assistance:</b> Gas/Propane, Water, Electric, other	Yes  No		<b>Legal Needs:</b> Child support, Criminal, Civil, other	Yes  No	
<b>Housing Needs:</b> Temporary Shelter, low income housing, Rent Assistance, Weatherization, Repairs Homeless	Yes  No		<b>Health Needs:</b> Immunizations, Medication, Mental Health Services, other	Yes  No	
<b>Heating/Cooling</b> Window Units Electric Heaters Gas heater	Yes  No		<b>Education:</b> GED, English as a Second Language, Vocation/Tech training, etc.	Yes  No	
<b>Child Care/ Elderly Care,</b> other	Yes  No		<b>Other needs</b> no identified on assessment	Yes  No	

**Authorizations**

I am an applicant of Cornerstone Community Action Agency. I hereby give my permission to release and verify all information requested including employment verification, utility bills and other data needed for program purposes.

I understand that I may request a hearing to appeal a denial of eligibility.

I give permission for my comments and picture to be taken for identification purposes, projects, publication, newsletter and promotional activities for Cornerstone Community Action Agency

The information provided on this application is true and correct to the best of my knowledge. I understand that I may be subject to prosecution for providing false or fraudulent information

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
CCAA Staff Signature

\_\_\_\_\_  
Date

**DECLARATION OF INCOME STATEMENT  
(DECLARACION DE INGRESOS)**

Applicant Name (Nombre del Solicitante)	Applicant Last Name (Apellido)	Suffix (Sufijo)
Address (Dirección)	City (Ciudad)	Zip Code (Código Postal)

State the gross income for household members, 18 years and older, who have no documentation of the income received in the **30-day period** prior to the date of application for assistance: *(Declarar el ingreso recibido por los miembros de su hogar, que tienen 18 años de edad ó mas, y que no tienen documentación de ingresos por los 30 días antes del aplicar para asistencia)*

Name (Nombre)	Gross Income Received (Ingreso Bruto Recibido)
Name (Nombre)	Gross Income Received (Ingreso Bruto Recibido)
Name (Nombre)	Gross Income Received (Ingreso Bruto Recibido)
Name (Nombre)	Gross Income Received (Ingreso Bruto Recibido)

My household has no documented proof of income due to the following situation:  
*(Mi hogar no tiene prueba para documentar los ingresos por medio de tal razones):*

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I certify that the above information is true and correct to the best of my knowledge and belief. *(Yo certifico que la información proveida de los ingresos es verdadera y correcta según mi saber y creencia.)*

I understand that the information will be verified to the extent possible; and that I may be subject to prosecution for providing false or fraudulent information. *(Comprendo que la información será verificada hasta donde sea posible y que puedo ser enjuiciado por haber proveido información falsa ó fraudulenta.)*

*(Applicant Signature/Firma del Solicitante)* \_\_\_\_\_

*(Date/Fecha)* \_\_\_\_\_

**CORNERSTONE COMMUNITY ACTION AGENCY  
COMMUNITY SERVICES**

## Self-Certification of Disability

Applicant's Name:	
Name of Person with Disability:	
Relationship of Person with Disability to Applicant:	

**Persons with Disabilities--Any individual who is:**

- A handicapped individual as defined in §7(9) of the Rehabilitation Act of 1973;
- Under a disability as defined in §1614(a)(3)(A) or §223(d)(1) of the Social Security Act or in §102(7) of the Developmental Disabilities Services and Facilities Construction Act; or
- Receiving benefits under 38 U.S.C. Chapter 11 or 15.

**APPLICANT'S AUTHORIZATION TO DECLARE DISABLED STATUS:**

I hereby authorize for the purpose of confirming my eligibility as a Person with Disability, in accordance with the above-stated definition of Person with Disability.

\_\_\_\_\_  
Signature of Person with Disability or His/Her Guardian

\_\_\_\_\_  
Date

# For ATMOS Clients Only



## CLIENT CONSENT AND RELEASE OF INFORMATION

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MAACLink is a computer system that is used locally as a Homeless Management Information System (HMIS). Use of an HMIS is required by the US Department of Housing and Urban Development (HUD) for agencies that receive HUD funding. MAACLink is not electronically connected to HUD and is only used by authorized agencies. All MAACLink users have received confidentiality training and have signed strict agreements to protect clients' personal information and limit its use appropriately.

A Privacy Notice is available at participating agencies. It provides details on how member agencies and their employees handle client information and data sharing.

Cornerstone Community Action Agency

I give permission to \_\_\_\_\_ (Agency Name) to collect and enter my personal and household information into the MAACLink computer system.

I understand that the MAACLink system is shared with and used by authorized agencies in my community for the purposes of:

1. Assessing the needs of low-income, homeless or other special-needs people in order to give better assistance and to improve their current or future situations.
2. Improving the quality of care and service for people in need.
3. Tracking the effectiveness of community efforts to meet the needs of people who have received assistance.
4. Reporting data on an aggregate level that does not identify specific people or their personal information.

I understand that:

- Information I give about my physical or mental health will NOT be shared outside the agency I am working with.
- I have the right to view my MAACLink file with an authorized user.
- Signing this release form does not guarantee that I will receive assistance.
- I may revoke my authorization by completing a revocation form.
- All agencies that use MAACLink will treat my information with respect and in a professional and confidential manner.
- Unauthorized people or organizations cannot gain access to my information without my consent.
- If I receive services from Homeless Prevention Rapid Re-Housing Federal Stimulus (HPRP) Funds, my information may be viewed by other participating agencies across Continuums of Care.

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Client Name (Printed)

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Client Signature

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Date

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Agency Representative Name (Printed)

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Agency Representative Signature

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Date