



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 _____ MI. _____

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 Residency _____ Rent _____ Own _____

Single Family Dwelling _____ Multi 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 Veteran | Surviving Spouse | Dependent of Veteran

If applying for Veterans General Assistance, please provide all income documentation on (taxable and non-taxable) income and all assets to demonstrate a financial need.

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

I certify that the above information is true and correct to the best of my knowledge and belief. *(Yo certifico que la información proveída 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 proveído 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

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.

Client Name (Printed)

Client Signature

Date

Agency Representative Name (Printed)

Agency Representative Signature

Date