

# ANOKA COUNTY COMMUNITY ACTION PROGRAM, INC.

1201 89<sup>th</sup> Avenue NE • Suite 345 • Blaine, MN 55434  
Phone 763-783-4747 • FAX 763-783-4700 • Website: [www.accap.org](http://www.accap.org)



## CRISIS ASSISTANCE

Anoka County Community Action Program, Inc. (ACCAP) may be able to assist you.

The ACCAP Crisis Committee meets as needed to review complete applications.

Applications that are NOT complete will NOT be reviewed.

Completed Applications may take up to 10 business days to process

**Follow the checklist** below to ensure your application is complete.

**CHECKLIST** - You must complete the ACCAP Crisis Application. This includes:

- The ACCAP Crisis Assistance Application
- The Crisis Assistance Monthly Budget Worksheet
- The Agency Intake form (*all adults in the household must sign the last page of this form*)
- Proof of income for ALL household members for 1 month
- Provide backup documentation for your request such as an **estimate or bid or invoice \*\***
- You may attach an explanation letter if necessary
- ALL questions must be answered

If we request additional information, and this information is not provided within 30 (thirty) days, your application will expire and therefore will be denied.

**ACCAP Crisis Assistance is limited up to \$1,000 total per household per lifetime.**

\*\* Payments are not made directly to clients. If approved, your vendor/contractor must be willing to accept a letter of guarantee for payment. Checks are not finalized until the work is complete. Checks generally take 2-3 weeks to process from time of final invoice.

If you or anyone in your household is in **SANCTION**, your application will be automatically denied.

If false information is given on the application, it will be denied and you cannot reapply in the future for ACCAP Crisis Assistance.

Our funding is for current Anoka County residents.  
We do not assist people with moving into Anoka County.

Please send completed forms to ACCAP Crisis Committee by FAX: 763-783-4700 or scan and email to [accap@accap.org](mailto:accap@accap.org) or you can bring it to our office located at  
1201 89<sup>th</sup> Avenue #345 Blaine, MN 55434.

# ACCAP Crisis Assistance Application

Name \_\_\_\_\_

## Type of Assistance Requested and Amount

- Frozen Pipes \$ \_\_\_\_\_
- Medical/Dental Costs \$ \_\_\_\_\_
- Moving Assistance \$ \_\_\_\_\_
- Plumbing Issues \$ \_\_\_\_\_
- Prescription Medications \$ \_\_\_\_\_
- Utility bills\*\* \$ \_\_\_\_\_  Natural Gas  Delivered Fuel  Electricity
- Other: \_\_\_\_\_ \$ \_\_\_\_\_

**\*\*Please note:** If you received Energy Assistance, you are not eligible for assistance for fuel/electricity. You must first contact Emergency Assistance (through Anoka County) and Heatshare and provide documentation of response from worker.

I authorize Anoka County Community Action Program, Inc. to exchange necessary information to provide assistance to me with the following vendor(s) \_\_\_\_\_ to resolve my crisis situation.

Client signature \_\_\_\_\_ Date: \_\_\_\_\_

What caused you to be in crisis?

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What steps have you taken to ensure this will not happen again?

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Have you received Crisis Assistance in the past?  NO  Yes, If yes, what for and when \_\_\_\_\_

Are you an ACCAP employee or related to an ACCAP employee?  Yes  NO

Do you have an ARMHS Worker?  NO  Yes, Name \_\_\_\_\_

Do you authorize us to exchange information with your ARMHS Worker?  Yes  NO

Do you have a REP Payee?  NO  Yes, Name \_\_\_\_\_

Do you authorize us to exchange information with your Rep Payee?  Yes  NO

# Crisis Assistance Monthly Budget Worksheet

## Monthly Household Income *(Include all sources for all household members)*

Wages(monthly) \$ \_\_\_\_\_  
Tips/Bonus \$ \_\_\_\_\_  
Unemployment \$ \_\_\_\_\_  
Child Support \$ \_\_\_\_\_  
Alimony \$ \_\_\_\_\_  
Spousal Maintenance \$ \_\_\_\_\_

SSI/RSDI \$ \_\_\_\_\_  
Retirement/Pension \$ \_\_\_\_\_  
Other: \_\_\_\_\_ \$ \_\_\_\_\_  
FOOD Support/SNAP \$ \_\_\_\_\_  
Economic Assistance \$ \_\_\_\_\_  
*(GA, MFIP, DWP, MSA)*

**Total Income**

## Monthly Household Expenses *(Be sure to answer ALL questions)*

### HOUSING

Mortgage \$ \_\_\_\_\_  
Rent \$ \_\_\_\_\_  
Lot Rent \$ \_\_\_\_\_

Association Fees \$ \_\_\_\_\_  
Insurance \$ \_\_\_\_\_  
Other: \_\_\_\_\_ \$ \_\_\_\_\_

### UTILITIES

Heating Costs \$ \_\_\_\_\_  
Electricity \$ \_\_\_\_\_  
Water/Sewer/Garbage \$ \_\_\_\_\_

Landline Phone \$ \_\_\_\_\_  
Cell Phone \$ \_\_\_\_\_  
Cable/Internet \$ \_\_\_\_\_

### TRANSPORTATION

Car Payment \$ \_\_\_\_\_  
Insurance \$ \_\_\_\_\_  
Gasoline \$ \_\_\_\_\_

Bus Pass \$ \_\_\_\_\_  
Other: \_\_\_\_\_ \$ \_\_\_\_\_

### OTHER

Day Care \$ \_\_\_\_\_  
Child Support *(Paid Out)* \$ \_\_\_\_\_  
Household Items \$ \_\_\_\_\_  
Personal Care Item \$ \_\_\_\_\_  
Medical/Dental \$ \_\_\_\_\_  
*(Premiums, Prescriptions)*

Credit Card Loans \$ \_\_\_\_\_  
School/Education \$ \_\_\_\_\_  
Food \$ \_\_\_\_\_  
Clothes \$ \_\_\_\_\_  
Other: \_\_\_\_\_ \$ \_\_\_\_\_

### Additional Expenses (please explain):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Total Expenses**

### MUST SIGN HERE

By signing this form, I affirm that I believe these facts are accurate and true. I know that I may be asked to prove my statements.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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1201 89<sup>th</sup> Avenue NE Suite 345

Blaine, MN 55434

Phone: 763-783-4747 Fax: 763-783-4700 Email: [accap@accap.org](mailto:accap@accap.org)[www.accap.org](http://www.accap.org)

## CLIENT INTAKE FORM

HEAD OF HOUSEHOLD										
First Name	Middle Name	Last Name	Primary Phone		Secondary Phone		Primary Language			
Address			City		Zip		Email			
HOUSEHOLD MEMBERS										
Full Name of all household members including yourself	Date of Birth	Social Security Number	Gender (see key)	Race (see key)	Hispanic Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Status (see key)	Disability (see key)	Military Status (see key)	Education (see key)	Health Coverage (see key)
Self (Same as above) 1.	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No					
2.	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No					
3.	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No					
4.	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No					
5.	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No					
6.	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No					
7.	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No					
KEY										
Gender	Race	Work Status	Disability	Military Status	Education	Health Coverage				
(M) Male (F) Female (O) Other	(A) Asian (I) American Indian/Alaskan Native (B) Black/African American (W) White (M) Multi-racial (H) Native Hawaiian/Pacific Islander (O) _____	(F) Full Time (P) Part Time (C) Contract (T) Temporary (R) Retired (L) Unemployed 6 months or less (M) Unemployed more than 6 months (U) Unemployed not seeking work (S) Migrant Seasonal Farm worker (N) Child- No work	(N) None (P) Physical (M) Mental (C) Cognitive (V) Visual (B) Blind (S) Speech (H) Hearing (D) Deaf (A) Breathing (R) Orthopedic (O) Other _____	(N) None (V) Veteran (A) Active Status	(S) 0-8 <sup>th</sup> grade (N) 9-12 Non-Grad (G) Highschool Grad (E) GED/Equivalent (P) Some College (D) 2 or 4 year degree	(M) Medicaid/Minnesota Care (S) Medicare (C) State Child (A) Military (D) Direct Purchase (E) Employer Coverage (N) No Health Insurance				

## HOUSEHOLD INCOME

Name <i>Example: John Doe</i>	Source and Monthly Income <i>C \$ 350</i>	Key	
1.	_____ \$ _____ \$	(A) Annuities (C) Child Support (D) Dividends/Interest	(B) Self-Employed (S) Social Security (I) Supplemental Security Income
2.	_____ \$ _____ \$	(E) Earned Income/Wages (F) No Income	(H) Social Security Disability Insurance (V) Veterans Benefits
3.	_____ \$ _____ \$	(G) General Assistance (M) MFIP	(U) Unemployment Benefits (W) Workers Compensation
4.	_____ \$ _____ \$	(W) DWP (R) Retirement	(O) Other _____
<b>Non-Cash Benefits</b> <input type="checkbox"/> SNAP <input type="checkbox"/> WIC <input type="checkbox"/> LIHEAP/EAP <input type="checkbox"/> Housing choice voucher <input type="checkbox"/> Public housing <input type="checkbox"/> Permanent supportive housing <input type="checkbox"/> HUD-VASH <input type="checkbox"/> Childcare voucher <input type="checkbox"/> Affordable Care Act Subsidy <input type="checkbox"/> Other _____	<b>Household type</b> <input type="checkbox"/> Single person <input type="checkbox"/> Two parents with children <input type="checkbox"/> Single parent- Female <input type="checkbox"/> Single parent- Male <input type="checkbox"/> Two adults/No children <input type="checkbox"/> Non-related adults with children <input type="checkbox"/> Multigenerational household <input type="checkbox"/> Other _____	<b>Housing Situation</b> <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Own home/rent lot <input type="checkbox"/> Homeless <input type="checkbox"/> Living with family/friends <input type="checkbox"/> Other permanent housing <input type="checkbox"/> Other _____	<b>Special Circumstances</b> <input type="checkbox"/> Domestic Abuse <input type="checkbox"/> Pregnant Teen <input type="checkbox"/> Non-Parent Caregiver <input type="checkbox"/> Parenting <input type="checkbox"/> English Language Learner <input type="checkbox"/> TANF/MFIP/DWP <input type="checkbox"/> Other _____

This form asks for data about you and your family. If you decide not to complete this form, we may not be able to provide you with all helpful information and resources. If you complete this form, we will use the information to identify resources, provide you with information, coordinate services, and create summary data for evaluation and funding purposes. Only ACCAP Staff will use the data on this form. You must consent for ACCAP to share this information with any other agency

**Consent to Exchange Information:** I authorize Anoka County Community Action Program, Inc. (ACCAP) to share this information with county, state and local welfare agencies, community-based organizations, local, state, public and private human service and housing agencies, the MN Department of Jobs and Training, the United States Department of Labor, the United States Department of Health and Human Services, and State and local education programs. I agree to allow Anoka County to share information with ACCAP. This consent will be valid for a period of one year or the duration of the services for which you are applying (if service is longer than one year).

Signature of Head of Household \_\_\_\_\_ Date \_\_\_\_\_

Signature of 2<sup>nd</sup> Adult Household Member \_\_\_\_\_ Date \_\_\_\_\_

Signature of 3<sup>rd</sup> Adult Household Member \_\_\_\_\_ Date \_\_\_\_\_

Signature of 4<sup>th</sup> Adult Household Member \_\_\_\_\_ Date \_\_\_\_\_

**ADDITIONAL HOUSEHOLD MEMBERS**

Full Name of all household members	Date of Birth	Social Security Number	Gender (see key)	Race (see key)	Hispanic Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Status (see key)	Disability (see key)	Military Status (see key)	Education (see key)	Health Coverage (see key)
8.	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No					
9.	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No					
10.	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No					
11.	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No					
12.	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No					
13.	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No					
14.	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No					

**KEY**

Gender	Race	Work Status	Disability	Military Status	Education	Health Coverage
(M) Male (F) Female (O) Other	(A) Asian (I) American Indian/Alaskan Native (B) Black/African American (W) White (M) Multi-racial (H) Native Hawaiian/Pacific Islander (O) _____	(F) Full Time (P) Part Time (C) Contract (T) Temporary (R) Retired (L) Unemployed 6 months or less (M) Unemployed more than 6 months (U) Unemployed not seeking work (S) Migrant Seasonal Farm worker (N) Child- No work	(N) None (P) Physical (M) Mental (C) Cognitive (V) Visual (B) Blind (S) Speech (H) Hearing (D) Deaf (A) Breathing (R) Orthopedic (O) Other _____	(N) None (V) Veteran (A) Active Status	(S) 0-8 <sup>th</sup> grade (N) 9-12 Non-Grad (G) Highschool Grad (E) GED/Equivalent (P) Some College (D) 2 or 4 year degree	(M) Medicaid/Minnesota Care (S) Medicare (C) State Child (A) Military (D) Direct Purchase (E) Employer Coverage (N) No Health Insurance

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Signature of 5th Adult Household Member \_\_\_\_\_ Date \_\_\_\_\_

Signature of 6th Adult Household Member \_\_\_\_\_ Date \_\_\_\_\_

Signature of 7th Adult Household Member \_\_\_\_\_ Date \_\_\_\_\_