

Community Action Partnership

Housing Rehabilitation Program Application

Answer ALL Questions!
Incomplete applications WILL NOT be processed!

Street Address: _____
Legal Description of Property: _____

Single Family Dwelling Yes No
Mobile/Manufactured home Yes No
Is it on it's own lot Yes No
Does it have a permanent foundation
 Yes No

Year home constructed: _____

Is the home your principal residence?
 Yes No
Do you have legal ownership?
 Yes No

Describe repairs needed or problems with the house:

HOUSING EXPENSES AND PROPERTY INFORMATION

Do You:
Own Your own house Yes No Pay on a mortgage Yes No
Pay on a Contract for Deed Yes No Other _____

Amount of current housing payments-expenses:

First Mortgage (interest & principal) monthly _____
Does this include taxes & insurance Yes No (if yes skip the next 2 questions)

Property Taxes (annual) _____

Property Insurance (including flood) _____

Special Assessments (annual) _____

Other Mortgage payments secured by property _____

Home Improvement loans _____

Are you delinquent or in default on the mortgage, taxes, any federal debt or other loan or obligation: Yes No

Have foreclosure proceedings been started: Yes No

Identify judgments or liens against the property: _____

**Provide income information for all household members 18 years or older.
Use gross income unless stated otherwise. Verification is required.**

SOURCE OF INCOME	APPLICANT	CO-APPLICANT	OTHER ADULT	TOTAL
Employment/Salary				
Interest/Dividends				
Net Business Income				
Net Rental Income				
Social Security / SSI				
Pension/Retirement				
Child Support/Alimony				
Unemployment, Workers Comp, etc				
TANF, Welfare, etc				
Income from Assets				
Other				
TOTAL				

COMMENTS:

ASSETS // VERIFICATION REQUIRED

TYPE	CASH VALUE	INCOME	BANK NAME	ACCOUNT#
Checking				
Savings/CDs/Money Mkt.				
Stocks				
Life Insurance				
Residence				
Other Real Estate				
Miscellaneous				
TOTAL				

COMMENTS:

Are you or an immediate member of your family one of the following:

- an employee, agent, consultant or officers of Community Action Partnership
- an elected or appointed official of the State of North Dakota

Yes No

I/we certify under penalty of law, that the above information is full, true and complete to the best of my/our knowledge. I/we understand that any willful misstatement may be grounds for disqualification. My/our signature(s) below constitute our consent to verify information from any necessary source and verifies receipt of "WATCH OUT FOR LEAD-BASED PAINT POISONING".

Signature

Date

Signature

Date

Today's Date

Community Action Partnership

Dickinson / Williston
CLIENT INTAKE FORM

Staff Initials _____

Please check Food Pantry Weatherization Rent/Security Deposit Home Rehab Head Start
All that apply: Electric Bill Water Bill Furnace/Water Heater Heating Bill Medications
 Senior Commodities Shelter VITA Payee Other _____

PERSONAL INFORMATION / HEAD OF HOUSEHOLD				
Social Security #	First Name	MI	Last Name	Birth Date (mm/dd/yyyy)
Gender	Disabled	Race		Ethnicity
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black	<input type="checkbox"/> Multi <input type="checkbox"/> Native American <input type="checkbox"/> Other	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> NOT Hispanic or Latino
Education		Food Stamps	Health Coverage	Veteran
<input type="checkbox"/> 0-8 th Grade <input type="checkbox"/> 9 th -12 th Grad (non-grad) <input type="checkbox"/> High School Grad/GED	<input type="checkbox"/> 12+ Grade <input type="checkbox"/> Associate Deg. <input type="checkbox"/> College Degree <input type="checkbox"/> Masters Deg.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Supplement <input type="checkbox"/> Other _____ <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No

INCOME INFORMATION				
Name	Pay/Hr	Hours/Week	Pay/Month	Source/Yr
	\$		\$	
	\$		\$	
	\$		\$	
	\$		\$	

Source Codes: A = Employment B = Unemployment C = Social Security D = TANF F = SSI/SSDI G=Pension
H= General Assistance I =Other

HOUSING INFORMATION			
Address	Apt/Lot#	City	County
Zip Code	Telephone #s		
	Home: _____ Work: _____		
Household Type		Marital Status	
<input type="checkbox"/> Female Single Parent <input type="checkbox"/> Single Female Living With Partner <input type="checkbox"/> Male Single Parent <input type="checkbox"/> Single Male Living With Partner <input type="checkbox"/> Two Parent	<input type="checkbox"/> Couple <input type="checkbox"/> Single <input type="checkbox"/> Other _____	<input type="checkbox"/> Single <input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Married
Housing Status	Housing Type	Rent/House Payment	
<input type="checkbox"/> Owner <input type="checkbox"/> Renter <input type="checkbox"/> Homeless with roof <input type="checkbox"/> Homeless without roof	<input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Duplex <input type="checkbox"/> Mobile Home	\$ _____ Rental Assistance <input type="checkbox"/> Yes <input type="checkbox"/> No	

ADDITIONAL HOUSEHOLD MEMBERS

Name (Please Print)		Social Security #		Birth Date		Age	
1.							
Relation	Gender	Disabled	Ethnicity Race	Education	Food Stamps	Health Coverage	Vet
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Name (Please Print)		Social Security #		Birth Date		Age	
2.							
Relation	Gender	Disabled	Ethnicity Race	Education	Food Stamps	Health Coverage	Vet
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Name (Please Print)		Social Security #		Birth Date		Age	
3.							
Relation	Gender	Disabled	Ethnicity Race	Education	Food Stamps	Health Coverage	Vet
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Name (Please Print)		Social Security #		Birth Date		Age	
4.							
Relation	Gender	Disabled	Ethnicity Race	Education	Food Stamps	Health Coverage	Vet
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Name (Please Print)		Social Security #		Birth Date		Age	
5.							
Relation	Gender	Disabled	Ethnicity Race	Education	Food Stamps	Health Coverage	Vet
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

APPLICANT CERTIFICATION

The information provided by me to establish my eligibility is true and accurate to the best of my knowledge. I consent to the independent verification of the information by the authorized agent of the agency or its government funding source

Applicant Signature

Date