Five County Association of Governments – Community Action (FCAOG CAP)
1070 West 1600 South, Building B, St. George, UT 84770
https://fivecountycap.org/apply-for-assistance/
Phone: (435) 674-5757 Fax: (435) 673-3540 email: capuser@fivecounty.utah.gov

Five County Association of Governments Community Action Intake & Consent Form

***PLEASE COMPLETE INFORMATION TO THE BEST OF YOUR KNOWLEDGE**

Five County Community Action Partnership (FCAOG CAP) has funding to help stabilize situation(s) and **improve self-sufficiency** (less dependency on government programs). Five County Association of Governments Community Action Partnership (FCAOG CAP) does not discriminate based on age, disability, genetic information, national origin, pregnancy, family composition, race/color, religion, sex, source of income, marital status, family composition, pregnancy, genetic information, source of income, sexual orientation/preference, and any protected classes outlined by federal and state law. As a department, we also do not discriminate based on sexual orientation or gender preference. However, Five County Community Action reserves the right to reserve service to clients under the following, non-protected circumstances:

- Causes any staff, volunteers, or other clients to feel threaten in any way. This includes sexual harassment, verbal and physical assault, displaying a weapon or a perceived weapon, and issuing threats.
- The client seeks services outside of walk-in hours and without a scheduled appointment.
- The client has been debarred from Five County assistance as a result of fraud, failure to comply with the terms of service, or any other documented reason.

What is REQUIRED of me?

- ✓ Gather all documents identified above. Understand incomplete documentation could delay or disqualify you for the services.
- ✓ Show up to appointment on time. If you are late without notice, you may be asked to reschedule.
- ✓ Report **ALL** income and provide proof of income (*pay stubs, social security, tax returns, or bank statements*), depending on funding source.

Five County also completes follow-ups to make sure things are going ok with you, please help us with this.

Please understand this application does not qualify and/or guarantee you for any particular level of funding

How long does it take? From the application to a check being cut typically takes at least 2 weeks. Five County will be in contact with your potential landlord during this time.

In order to expedite the intake process, submit the household income with your application (the last 30 days of income: *(pay stubs, social security, tax returns, or bank statements)*

Please bring all documents to your scheduled appointment. If documentation is not presented it could delay or disqualify you for the services you need (plan on about 60 minutes for your appointment):

☐ Complete Five County Association of Governments – Community Action Intake Packet
☐ Picture ID for everyone over 18 years old
☐ For gas voucher applicants: bring the driver's current auto insurance and driver's license
☐ Intake Assessment with Five County Community Action case manager (by appointment only)

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Five County Association of Governments Community Action Intake

PLEASE COMPLETE INFORMATION TO THE BEST OF YOUR KNOWLEDGE AND HONESTLY

Applicant Name: _____
FIRST LAST INITIAL SUFFIX

Address: _____ **City:** _____ **State:** _____

Zip: _____ **Main Phone #:** _____ ☐Cell ☐Home ☐Work **Alternate #:** _____ ☐Cell ☐Home ☐Work

Email: _____ **Contact Person:** if applicable _____

☐ I agree to receive emails regarding community events and resources

Housing Status: *(Check one)*
☐Stably Housed *(Circle one)*: rent own ☐ Renting, is it subsidized? Yes No ☐Emergency Shelter or the streets
☐ Friends/Family, are you paying rent to them? Yes No ☐Motel, who's paying for it? _____
☐ Other, please specify: _____

Length of Stay: *(Check one)*
☐ 1 day or less ☐ 2 days to 1 week ☐ more than 1 week, but less than 1 month
☐ 1 – 3 months ☐ More than 3 months, but less than 1 year ☐ 1 year or longer

Answering yes to any of these questions does not eliminate you from funding. Please answer honestly

Do you have an eviction notice? ☐ No ☐ Yes, what date was the eviction served?_____

Do you have any rent or utility back payments? ☐ No ☐ Yes, company(ies) you owe money to? _____

Are you fleeing Domestic Violence? ☐ No ☐ past 3 months ☐ 3-6 months ago ☐ 6 months-up to 1 year ago ☐ 1 year ago or more

Are you currently fleeing domestic violence? ☐ No ☐ Yes

Date your homelessness started (not always the date you entered the shelter): ____ / ____ / ____ *(mo/da/year)*

FINANCIAL INFORMATION

In order to accurately determine an individual's or household's gross income, the following sources must be considered in the income determination: 1) Gross earnings from employment (wages, salaries, tips, commissions, bonuses etc.), 2) Unemployment compensation (public or private), 3) Workers' compensation, 4) Social security, 5) Public assistance or welfare payments in the form of cash (TANF, SSI, non-federal General Assistance, or General Relief money payments), 6) Veterans' payments, 7) Survivor benefits, 8) Disability benefits, 9) Pension or retirement income, 10) Regular insurance or any type of annuity payments, 11) College or university scholarships, grants, fellowships, and assistantships, 12) Interest income on assets in excess of $10,000, 13) Dividends, 14) Rents, royalties, and estates and trusts, 15) Educational assistance, 16) Alimony, 17) Child support, 18) Financial assistance from outside of the household, 19) Other income (military family allotments or other regular support from an absent family member or someone living in the household, etc.), 20) If a person lives with a family, add up the income of all family members. (Non-relatives, such as housemates, do not count.)

Non-Cash Benefits Received [Last 30 Days]: please provide a copy of your 24-month benefits report from *mycase* on DWS website

☐ Food Stamps or Benefit Card $ _____
☐ WIC (Supplemental Nutrition for Women, Infants, and Children)
☐ Free or Reduced School Lunch
☐ Veteran's Administration (VA) Medical Services
☐ Section 8 Public Housing or Rental Assistance
☐ TANF Services (please specify): _____
☐ Medicare (Health Insurance)
☐ Medicaid (Health Insurance)
☐ SCHIP (State Children's Health Insurance Program)
☐ Indian Health Services Program
☐ PCN (Health Insurance)
☐ Other Non-Cash Benefits (please specify): _____

SIGNED STATEMENT

By signing below, I verify that the information I have provided is true and accurate to my knowledge.

Client (1) Signature _____ Date _____

Client (2) Signature _____ Date _____

FOR OFFICE USE ONLY:

Five County Community Action Case Manager Signature below:	Assessment Date:
	Application Completion Date:

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HOUSEHOLD INFORMATION

According to Community Action Program Legal Services (CAPLAW), **the income of all members of each individual family unit must be** included in determining the income eligibility. A family unit is either (1) related individuals: two or more persons related by birth, marriage, and/or adoption who reside together, or (2) an unrelated individual: an individual who is not an inmate of an institution and who resides alone or with one or more persons who are not related to him/her by birth, marriage, and/or adoption, excluding house mates (renters or leasers).

Family Type: *(Check one)*

☐ Single Person ☐ Multiple Adults (no children) ☐ Single Parent (circle one): Female Male other ☐ Two Parent Household

☐ Non-Related Adults with Children ☐ Multi-Generational Household ☐ Other, please explain: _____

Demographic information needed below	**Household #1** **Name** First, Middle, Last Name:	**Household #2** **Name** First, Middle, Last Name:	**Household #3** **Name** First, Middle, Last Name:
Relationship to head of household	self	Relationship:	Relationship:
Proof of Identity Only for 18 yrs. or older	Expires:	Expires:	Expires:
Phone Number, if different			
Email Address, if different			
Race options:	Am Indian/AK Native Asian Black/African American Pacific Islander Multi-race (2 or more) White	Am Indian/AK Native Asian Black/African American Pacific Islander Multi-race (2 or more) White	Am Indian/AK Native Asian Black/African American Pacific Islander Multi-race (2 or more) White
Hispanic, Latino, or Spanish Origin?	Yes No	Yes No	Yes No
Date of Birth Month/Day/Year			
Social Security #			
Gender (circle one)	Male Female Non-traditional gender	Male Female Non-traditional gender	Male Female Non-traditional gender
Education (circle one)	0-3 years old Pre-K – 8th grade Grades 9 – 12 HS grad/GED Some college 2-4 yrs of college Graduate degree	0-3 years old Pre-K – 8th grade Grades 9 – 12 HS grad/GED Some college 2-4 yrs of college Graduate degree	0-3 years old Pre-K – 8th grade Grades 9 – 12 HS grad/GED Some college 2-4 yrs of college Graduate degree
Disability?	Yes No Unknown	Yes No Unknown	Yes No Unknown
Military Service	Currently serving In the past Not a Veteran	Currently serving In the past Not a Veteran	Currently serving In the past Not a Veteran
Health Insurance	No Private Medicaid Medicare PCN Military Healthcare CHIP Employer Sponsored	No Private Medicaid Medicare PCN Military Healthcare CHIP Employer Sponsored	No Private Medicaid Medicare PCN Military Healthcare CHIP Employer Sponsored
Employment status	Un-Employed (0-6 months) Unemployed (6 months +) Full-Time Part-Time Migrant Seasonal Farm	Un-Employed (0-6 months) Unemployed (6 months +) Full-Time Part-Time Migrant Seasonal Farm	Un-Employed (0-6 months) Unemployed (6 months +) Full-Time Part-Time Migrant Seasonal Farm
Monthly Income Provide income verification with each income	$ _____/ mo. ☐ Tax Return ☐ Pay Stubs ☐ Bank Statement ☐ SSI/SSDI sheet ☐ DWS 24 mo Benefit Report	$ _____/ mo. ☐ Tax Return ☐ Pay Stubs ☐ Bank Statement ☐ SSI/SSDI sheet ☐ DWS 24 mo Benefit Report	$ _____/ mo. ☐ Tax Return ☐ Pay Stubs ☐ Bank Statement ☐ SSI/SSDI sheet ☐ DWS 24 mo Benefit Report
Disconnected Youth? Youth age 14-24 who is neither working nor in school	Yes No	Yes No	Yes No
Barriers currently present	☐ Alcohol Abuse ☐ Chronic Health Condition ☐ Developmental Disability ☐ Substance Abuse (past/current) ☐ Mental Health ☐ Physical Disability	☐ Alcohol Abuse ☐ Chronic Health Condition ☐ Developmental Disability ☐ Substance Abuse (past/current) ☐ Mental Health ☐ Physical Disability	☐ Alcohol Abuse ☐ Chronic Health Condition ☐ Developmental Disability ☐ Substance Abuse (past/current) ☐ Mental Health ☐ Physical Disability
Receiving care for above barriers?	Yes No	Yes No	Yes No

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HOUSEHOLD INFORMATION CONTINUED:

Demographic information needed below	**Household #4** **Name** First, Middle, Last Name:	**Household #5** **Name** First, Middle, Last Name:	**Household #6** **Name** First, Middle, Last Name:
Relationship to head of household	self	Relationship:	Relationship:
Proof of Identity Only for 18 yrs. or older	Expires:	Expires:	Expires:
Phone Number, if different			
Email Address, if different			
Race options:	Am Indian/AK Native Asian Black/African American Pacific Islander Multi-race (2 or more) White	Am Indian/AK Native Asian Black/African American Pacific Islander Multi-race (2 or more) White	Am Indian/AK Native Asian Black/African American Pacific Islander Multi-race (2 or more) White
Hispanic, Latino, or Spanish Origin?	Yes No	Yes No	Yes No
Date of Birth Month/Day/Year			
Social Security #			
Gender (circle one)	Male Female Non-traditional gender	Male Female Non-traditional gender	Male Female Non-traditional gender
Education (circle one)	0-3 years old Pre-K – 8th grade Grades 9 – 12 HS grad/GED Some college 2-4 yrs of college Graduate degree	0-3 years old Pre-K – 8th grade Grades 9 – 12 HS grad/GED Some college 2-4 yrs of college Graduate degree	0-3 years old Pre-K – 8th grade Grades 9 – 12 HS grad/GED Some college 2-4 yrs of college Graduate degree
Disability?	Yes No Unknown	Yes No Unknown	Yes No Unknown
Military Service	Currently serving In the past Not a Veteran	Currently serving In the past Not a Veteran	Currently serving In the past Not a Veteran
Health Insurance	No Private Medicaid Medicare PCN Military Healthcare CHIP Employer Sponsored	No Private Medicaid Medicare PCN Military Healthcare CHIP Employer Sponsored	No Private Medicaid Medicare PCN Military Healthcare CHIP Employer Sponsored
Employment status	Un-Employed (0-6 months) Unemployed (6 months +) Full-Time Part-Time Migrant Seasonal Farm	Un-Employed (0-6 months) Unemployed (6 months +) Full-Time Part-Time Migrant Seasonal Farm	Un-Employed (0-6 months) Unemployed (6 months +) Full-Time Part-Time Migrant Seasonal Farm
Monthly Income Provide income verification with each income	$ _____/ mo. ☐ Tax Return ☐ Pay Stubs ☐ Bank Statement ☐ SSI/SSDI sheet ☐ DWS 24 mo Benefit Report	$ _____/ mo. ☐ Tax Return ☐ Pay Stubs ☐ Bank Statement ☐ SSI/SSDI sheet ☐ DWS 24 mo Benefit Report	$ _____/ mo. ☐ Tax Return ☐ Pay Stubs ☐ Bank Statement ☐ SSI/SSDI sheet ☐ DWS 24 mo Benefit Report
Disconnected Youth? Youth age 14-24 who is neither working nor in school	Yes No	Yes No	Yes No
Barriers currently present	☐ Alcohol Abuse ☐ Chronic Health Condition ☐ Developmental Disability ☐ Substance Abuse (past/current) ☐ Mental Health ☐ Physical Disability	☐ Alcohol Abuse ☐ Chronic Health Condition ☐ Developmental Disability ☐ Substance Abuse (past/current) ☐ Mental Health ☐ Physical Disability	☐ Alcohol Abuse ☐ Chronic Health Condition ☐ Developmental Disability ☐ Substance Abuse (past/current) ☐ Mental Health ☐ Physical Disability ☐ Currently receiving public
Receiving care for above barriers?	Yes No	Yes No	Yes No

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For additional household members, please print this page again

SELF-SUFFICENCY STATEMENT

According to the Community Service Block Grant, "Self-sufficiency" is defined as:
The applicant needs to be achieving (or working towards) a set of goals which will result in greater self-sufficiency and will eliminate some of the causes of that family's poverty. What issues is the applicant facing and the resources the family (or community agencies the family is working with) brings to address these issues.

Below, please have a written plan toward self-support created within your family/household:

_____

_____

_____

_____

_____

_____

_____

_____

_____

EMPLOYMENT SUPPORT SERVICES OFFERED THROUGH CAP

Please checkmark the services you're seeking

- ☐ **FLEXIBLE GAS VOUCHER**
- ☐ **GED/APPLIED TECH SCHOLARSHIP**
- ☐ **DEPOSIT ASSISTANCE**
- ☐ **FOOD PANTRY**
- ☐ **MONTHLY BUS PASS**
- ☐ **STATE ID**
- ☐ **BIRTH CERTIFICATE**

1. **Would you like to request to be placed onto the housing list? ☐ No ☐ Yes**
   (*This is a 60-minute assessment in order to be placed onto the housing list)*
   In order to receive Rapid Re-housing assistance, you must be placed onto a housing list, which requires a "literally homeless" status. Literally homeless means you are sleeping in a place not meant for human habitation or fleeing domestic violence without permanent housing.
2. **Do you need help filing taxes ☐ No ☐ Yes**
3. **Are you interested in utility assistance (HEAT) and/or Weatherization? ☐ No ☐ Yes**
4. **Are there court fines that you'd like turned into Court Ordered Community Service? ☐ No ☐ Yes**

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Authorization to Release Information

The agencies listed below are designed to assist individuals/families experiencing a housing crisis. The Authorization is designed to permit those agencies to share client information in order to collaborate on services and promote housing stability.

Client Name: _____ Date of Birth: _____

Client Name: _____ Date of Birth: _____

Address: _____ Phone: _____

☐ **by checking this box, I approve all of the below listed agencies**

☐	Five County Association of Governments	☐	The Utah Food Bank & Local Food Pantries
☐	Department of Workforce Services (DWS)	☐	Iron County Care & Share
☐	Southwest Behavioral Health Center	☐	Intermountain Health Care
☐	Cedar City or St. George Housing Authority	☐	Canyon Creek Women's Crisis Center (Domestic Violence)
☐	Family Healthcare / Clinic	☐	DOVE Center (Domestic Violence)
☐	Vocational Rehabilitation	☐	Utility Companies (Questar Gas, Rocky Mountain Power, etc.)
☐	The Division of Child and Family Services	☐	Veteran's Administration & Southern Utah VA Home
☐	County Sheriff Offices in the Service Area	☐	Switchpoint Community Resource Center
☐	LDS Transient Bishop's Office Bishop you are working with: _____	☐	Other agencies/people the team may contact to assist in individual cases: (list):
☐	Iron or Washington County School District	☐	Family Members (list):
☐	Police Departments in the	☐	Other (list):
☐	Adult Protective Services (APS)	☐	Other (list):
☐	Adult Probation and Parole (AP&P)/ private parole agency	☐	Other (list):

Information to Be Released: Only authorized personnel will share client information needed for service delivery, program eligibility, to track demographic trends, service patterns and the client outcomes achieved. Non-personally identifying information may also be used for the purposes of research and reporting to other services agencies, current and potential program funding sources, and other programs offered by.

For the Purpose of: (a) providing coordinated housing, medical, social, psychological, and other services to me, (b) evaluating the outcomes related to service delivery, and (c) to improve coordination of services to assist individuals experiencing a housing crisis, and (d) to identify barriers and service gaps that block the path out of homelessness. In the event of the publication of the results of the program, my identity will be kept confidential, although information about my circumstances may be discussed.

Right to Revoke: This authorization is subject to revocation at any time except to the extent that the agencies which are to make the disclosures have already taken action in reliance on those disclosures. Unless otherwise revoked by client, this release expires after 1 year.

Potential Re-disclosure: In understand that information that I authorize to be disclosed may be re-disclosed and not subject to medical privacy regulations. However, federal confidentiality rules (42 CFR, part 2) prohibit recipients from making any further disclosure of alcohol and substance abuse records unless further disclosure is expressly permitted by written consent of the person to whom they pertain or if disclosure is otherwise permitted by 42 CFR, part 2. The Federal rules restrict any use of the information to criminally investigate or prosecute and alcohol or drug abuse client.

By signing below, I authorize the above listed organizations to share information as it relates to my housing needs.

_____ _____

Client (1) Signature Date

_____ _____

Client (2) Signature Date

_____ _____

Case Manager Signature Date

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CSBG Income Guidelines
Department of Health & Human Services Poverty Guidelines

All clients receiving CSBG services must be able to demonstrate that they are eligible for the CSBG Program and the Household income is at or below **125%** of Federal Poverty Guidelines.

2019 Poverty Guidelines

Household size	Monthly	Annual
1	$1,301	$15,613
2	$1,761	$21,138
3	$2,222	$26,663
4	$2,682	$32,188
5	$3,143	$37,713
6	$3,603	$43,238
7	$4,064	$48,763
8	$4,524	$54,288
9	$4,984	$59,813
10	$5,445	$65,338

Guidelines are found at: https://aspe.hhs.gov/poverty-guidelines

Five County Community Action Grievance Procedure

This Grievance Procedure is to be followed by program consumers who are dissatisfied with or are denied services under programs funded by Community Service Block Grant (CSBG), Social Service Block Grant (SSBG), and any other grant or program overseen by the Five County Human Services Council. Attempts will be made to resolve grievances as quickly as possible.

Informal: Consumer will bring issue to attention of the local program provider. If not resolved to consumer's satisfaction, the consumer has the option of pursuing the grievance by issuing a formal complaint.

Formal Complaint

a. Consumer will submit written grievance to local program provider within five (5) working days of the incident or of knowledge of the incident. The local Program Provider will respond in writing within ten (10) working days. If not resolved to consumer's satisfaction, they have option to proceed.
b. If the issue is still not resolved to consumer's satisfaction, consumer may submit written grievance within ten (10) working days to Director of Community Action, Five County Association of Governments, 1070 West, 1600 South, Building B, St. George, Utah 84770. The Director of Community Action will respond in writing within ten (10) working days. If not resolved to consumer's satisfaction they have option to proceed.
c. If the issue is still not resolved to consumer's satisfaction, consumer may submit written grievance within ten (10) working days to the Executive Director of the Five County Association of Governments, 1070 West 1600 South Building B, St. George, Utah 84770. The Executive Director will utilize support staff or Human Services Council support as deemed necessary to investigate information and render a decision regarding the grievance. The Executive Director will respond in writing within ten (10) working days. If not resolved to consumer's satisfaction, they have option to proceed.
d. If the issue is still not resolved to consumer's satisfaction, consumer will be provided with address and telephone number(s) for the Chairperson of both the Five County Human Services Council and Five County Association of Governments Steering Committee. A hearing before the Human Services Council will offer the next level of grievance and help remedy appropriate action(s) regarding the complaint. The nature of the complaint and the investigation shall be properly documented. The response to the consumer will address the complaint received and relevant action taken. If any member of Human Services Council has involvement in the grievance, those members shall exclude themselves from the grievance procedure.
e. If the decision is not to the satisfaction of the consumer, the consumer shall be referred to the appropriate state agency's grievance procedure. In most instances, this will be the Utah Department of Workforce Services or the Utah Department of Human Services.

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UHMIS Informed Consent Release Form

(only for Homeless applicants)

PLEASE READ THE FOLLOWING STATEMENTS.

MAKE SURE YOU HAVE HAD THE CHANCE TO HAVE YOUR QUESTIONS ANSWERED.

FCAOG CAP is part of the Utah Homeless Management Information System (UHMIS).
UHMIS is a system that uses computers to collect information about homelessness. The reason for UHMIS is to track funding for homeless programs given by many funders. The goal is to simplify service delivery to people in need.
UHMIS operates over the internet and uses many security protections to keep your information safe. Many service providers across Utah use UHMIS, so your information will be shared with other service providers that provide similar services. Information collected is housed in a secure server located at Data System International (DSI), in Sandy, Utah. DSI employees have access to this server and the data housed there, but only for network support and maintenance purposes. UHMIS staff and approved Utah State Community Services Office (SCSO) staff collect and use only information that is needed for reports on homelessness to help inform policy decisions. Every person with access to this information must sign and comply with all confidentiality agreements.

To better provide services to you in the best way **possible** **FCAOG CAP** is asking your permission to share your information with the other approved UHMIS participating agencies in Utah. This will include sharing the following information about you and any dependent minor children with you:

- **Name, gender, partial SSN, birth date**

By signing this form you are letting us share your information, and the information of your dependent children under the age of 18 with other UHMIS participating agencies. This information will be accessible for seven years from the last date of service.
You may cancel this consent at any given time by written request to this agency. The cancellation will not be applied to records already collected from you. If you choose to not give consent, it **does not** make you ineligible to receive services unless you are applying for the Homeless Prevention and Rapid Re-housing Funding (HPRP or TANF).

Your Rights

- You have the right to get non-UHMIS, services even if you choose **NOT** to participate in the UHMIS.
- You have the right to ask who has seen your information.
- You have the right to see your information and to change it if it's not correct. But you must show documentation.

A list of participating agencies is available from your case manager or online at **http://hmis.utah.gov**. If you don't want your information shared with a specific agency, please let your case manager or intake worker know. He/she can then take the proper action to honor your request.

****PLEASE READ CAREFULLY****

We collect personal information directly from you for reasons that are discussed in our privacy statement. We may be required to collect some personal information by law or by organizations that give us money to operate this program. Other personal information that we collect is important to run our programs, to improve services for homeless persons, and to better understand the needs of homeless persons. We only collect information that we consider to be appropriate. If you have any questions or would like to see our privacy policy, our staff will provide you with a copy.

SIGNATURE OF CLIENT/GAURDIAN	DATE
PRINTED NAME OF CLIENT	DOB OF CLIENT
SIGNATURE OF INTAKE WORKER/CASE MANAGER	