



APPLICATION FOR THE FOLLOWING SERVICES
UTILITIES
RENT
MORTGAGE
EMERGENCY SHELTER

YOUR APPLICATION CAN BE TURNED IN AS FOLLOWS:

FAX: 815-933-0635

EMAIL: HSERVICESFORMS@KCCSI-CAP.ORG

MAIL 657 E. COURT ST.
DROP OFF: KANKAKEE IL 60901 (SUITE 207 or DROP BOX)

IF YOU DROP THE INFORMATION OFF, IT MUST BE IN A SEALED ENVELOPE. YOU CAN SUBMIT WHAT YOU HAVE, WE WILL REQUEST ADDITIONAL INFORMATION IF NEEDED!

YOU MUST SUBMIT THE PACKET AND DOCUMENTS NO LATER THAN 15 DAYS FROM THE DATE IT IS SIGNED. IF IT IS RETURNED AFTER THE 15 DAYS, THE AGENCY RESERVES THE RIGHT TO REQUEST ADDITIONAL INFORMATION.

****ALL REQUESTS FOR UTILITY ASSISTANCE WILL FIRST BE REFERRED TO KCCSI'S LIHEAP AND/OR LIHWAP PROGRAMS****

SEE PAGE 2 FOR THE INFORMATION YOU NEED TO SUBMIT WITH YOUR APPLICATION

Please contact KCCSI staff if you have any questions.

Phone: 815 933 7883

Hours: M-F 8:00am to 5:00pm



**WEBSITE kccsi-cap.org * 657 E. COURT ST., SUITE 207 * KANKAKEE, IL 60901
PHONE 815-933-7883 * FAX 815-933-0635**

The following items are needed to begin the application process within the Community Services Department of KCCSI. Please submit all the items with the packet.

Additional information may be required.

- ☐ **PHOTO ID WITH A KANKAKEE COUNTY ADDRESS FOR EVERYONE 18 AND/OR OLDER** *(cannot be expired)*
- ☐ **SOCIAL SECURITY CARDS FOR EVERYONE**
- ☐ **PROOF OF INCOME FROM ALL SOURCES FOR THE PAST 30 DAYS**
 - IF ANYONE 18 OR OLDER DOES NOT HAVE INCOME, THAT PERSON MUST PROVIDE A PRINTOUT FROM IDES AND COMPLETE A 0-INCOME AFFIDAVIT
- ☐ **MEDICAL CARD**
- ☐ **CURRENT SNAP (FOOD STAMPS) NOTICE OF DECISION**
- ☐ **PROOF EMERGENCY OR NEED:**
 - 1. 5-DAY EVICTION NOTICE *or*
 - 2. COURT ORDERED EVICTION *or*
 - 3. FIRE REPORT *or*
 - 4. CODE ENFORCEMENT EVICTION *or*
 - 5. LETTER FROM THE PERSON YOU ARE CURRENTLY STAYING WITH STATING THAT YOU CANNOT STAY WITH AND WHY *or*
 - 6. MORTGAGE ARREARAGE STATEMENT
- ☐ **CURRENT SIGNED LEASE**
- ☐ **THOSE REQUESTING SHELTER MUST ALSO SUPPLY A CURRENT ALPHA REPORT THAT IS DATED WITHIN THE PAST 30 DAYS**
- ☐ **THOSE REQUESTING UTILITY ASSISTANCE MUST SUPPLY THE MOST RECENT UTILITY BILL (MUST SHOW A PAST DUE BALANCE) AND DISCONNECTION NOTICE**
- ☐ **THOSE WHO RECEIVED A REFERRAL MUST SUBMIT A COPY OF THE REFERRAL TO THE AGENCY**

The packet with the requested information must be returned no later than 15 days from the date it is signed. If it is returned after the 15 days, the agency reserves the right to request additional information. The agency reserves the right to request proof of income for the past 90-days.

DATE

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Program: Human Services Service Requested:

Head of Household Name:

First

Middle Initial

Last

Social Security Number:

Address

City

Zip

Phone Number ()

Marital Status

Primary Language

Family Size #

Housing Status RENT / OWN / OTHER

Rent Amount \$

Do you receive Food Stamps? YES / NO

If yes, amount \$

Do you have health insurance? YES / NO

Is the Head of Household any of the following:

FARMER

SEASONAL FARMER

VETERAN

ALL Family Members:

| Social Security Number | Name Last, First | Relationship | Date of Birth | Age | Sex | Disabled? | Race | Education Level | 30/90-day income | Source of Income |
|------------------------|---------------------|--------------|------------------|-----|-----|-----------|------|--------------------|---------------------|---------------------|
| | | HOH | | | | | | | | |
| | | | | | | | | | | |
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Do/did services provided help you to become self-sufficient? Yes No

TOTAL FAMILY INCOME

Applicant statement: I certify that the information contained in my application is an accurate and complete disclosure of the requested information. I hereby acknowledge that the information relating to determination of my eligibility requires verification and/or documentation, and by my signature I authorize others to release information as may be required for the determination of my eligibility.

Signature of HOH:

Date

KCCSI signature:

Date

YOUR EMAIL ADDRESS:

Head of Household Name: _____ First _____ Middle Initial _____ Last _____ Social Security Number: _____ - _____ - _____

LIST ADDITIONAL FAMILY MEMBERS HERE:

| Social Security Number | Name Last, First | Relationship | Date of Birth | Age | Sex | Disabled? | Race | Education Level | 90 day income | Source of Income |
|------------------------|---------------------|--------------|------------------|-----|-----|-----------|------|--------------------|------------------|---------------------|
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Signature of HOH: _____ Date _____

| REQUEST FOR SERVICES | RESPONSE |
|---|--|
| Who in the home is requesting assistance? | |
| What service are you requesting? <i>Circle all that apply</i> | <p>EMERGENCY SHELTER / RENT HELP</p> <p>UTILITY HELP / MORTGAGE HELP</p> |
| Did you receive any of the following? <i>Circle all that apply</i> | <p>EVICTIION NOTICE / PAST DUE MORTGAGE</p> <p>DISCONNECTION NOTICE / HOMELESS</p> |
| If you are homeless, please provide a brief explanation of why. | <hr/> <hr/> <hr/> |
| For all other service requests, what happened that caused you to fall behind? | <hr/> <hr/> <hr/> <hr/> |
| How much are you behind? | <hr/> <hr/> |
| Did you try to make a payment arrangement? | YES / NO |
| What was the arrangement? | <hr/> <hr/> <hr/> <hr/> |
| If you did make an arrangement and could not uphold it, why? | <hr/> <hr/> <hr/> <hr/> |

+++++
90 Day Income - BREAK DOWN

| Source | Amount |
|-----------------|--------|
| Employment | |
| Pension | |
| TANF | |
| Food Stamps | |
| Social Security | |
| SSI | |
| Unemployment | |
| Child Support | |
| Other | |

As the head of household, Are you currently employed Yes _____ No _____

Please list your last 2 jobs

Employer 1: _____ Position Held: _____

Start Date: _____ End Date: _____

Full Time / Part Time _____ Rate of Pay: _____

Reason Leaving: _____

Employer 2: _____ Position Held: _____

Start Date: _____ End Date: _____

Full Time / Part Time _____ Rate of Pay: _____

Reason Leaving: _____

+++++

As the Head of Household, Are you satisfied with your current education? Y / N

Highest level of Education you completed: _____

Name of institution: _____

Location: _____

Last year of attendance: _____

Type of degree, if any: _____

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Do you have a current driver's license? Y / N

Do you have a car with insurance? Y / N

Do you use public transportation? Y / N

+++++

Do you use local pantries? Y / N

Are you ever hungry and skip meals? Y / N

+++++

**Are you experiencing any problems that
counseling or mental health services might help you with? Y / N**

+++++

Do you use alcohol or drugs? Y / N

**Would you like information about
support groups? Y / N**

+++++

Are you currently homeless? Y / N

If not homeless:

Do you rent? Y / N

Do you stay with someone? Y / N

Is your rent Subsidized? Y / N

How much is your rent? \$ _____

Do you own your home? Y / N

How much is mortgage payment? \$ _____

What utilities do you pay? water sewer gas electric (Circle all that apply)

Do you have shut offs (disconnection notices) on any of the bills? Y / N

If so, which one(s) _____

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Are any of your children having problems in school? Y / N

Do you currently have an open case with DCFS? Y / N

Are you experiencing any stress that negatively impacts your family? Y / N

Do you need child care to be able to work? Y / N

If you have child care, how much do you pay? \$ _____

Please check all that apply

| Question | Yes | No |
|---|------------|-----------|
| Do you have birth certificates for all family members | | |
| Do you have social security cards for all family members | | |
| Are all adults registered to vote | | |
| Are the children up to date on immunizations | | |
| Do the children receive regular medical check ups | | |
| Have you ever been to prison | | |
| Are you on parole or probation | | |
| Do you volunteer in the community | | |
| Are you the primary care giver for a seriously ill family member | | |

Please list your short term (3-6 month) goals here:

Please list your long term (1 year or more) goals here:

Universal Signature Page/ PÁGINA DE FIRMA UNIVERSAL

IMPORTANT NOTICE: This state of Illinois grantee agency, Kankakee County Community Services, Inc., is requesting disclosure of information that is necessary to accomplish a complete application for:

| | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Community Service Block Grant (CSBG) |
| <input type="checkbox"/> | Illinois Home Weatherization Assistance Program (IHWAP or Weatherization) |
| <input type="checkbox"/> | Low Income Home Energy Assistance Program (LIHEAP or Energy Assistance), including the Percentage of Income Payment Plan (PIPP) program |

APPLICANT STATEMENT: I certify that the information I have provided is an accurate and complete disclosure of the requested information. I also certify that every household member in the application is a resident of Illinois.

I authorize this agency to verify the information and contact my utility/fuel supplier, landlord, employer and/or other sources for verification or additional information and to exchange information contained in or otherwise used regarding my application and participation in CSBG/LIHEAP/IHWAP.

For LIHEAP and IHWAP I also authorize the Department of Commerce & Economic Opportunity and my utility/fuel supplier to share my usage and bill information during the twenty-four (24) month period prior to and twelve (12) month period after the date of my application submittal and/or completion of LIHEAP and IHWAP services for the purpose of program evaluation and analysis.

I have received information outlining my appeal rights. I understand that filling out this application does not guarantee that my household will receive assistance. I understand I will be provided a copy of this application for my future reference.

Applicant Name/ Nombre: _____

Applicant Signature/Firma: _____ Date: _____

Personal and Family with Zero-Income Affidavit

This form must be completed if the applicant or a family member in their household is 18 years and older and has reported no income for the last 90 days.

| | |
|-------------------------|--|
| Applicant's Name | |
| Household Member | |
| Household Member | |
| Household Member | |
| Household Member | |
| Household Member | |

I hereby certify that those listed above have no income. We met our basic living expenses by:

I certify that the information above is true and correct. I understand I may be required to provide proof of any information given. I understand that providing false information will result in the denial of my application.

Applicant/Head of Household Signature

Printed Name If Head of Household



Responsibility of Benefits & Disclosure

By signing below:

I understand that it can take 60-90 days for the vendor to receive payment from the date my application is approved.

I understand that I may not receive benefits because of federal funding cuts and/or exhaustion of benefits, even if I am determined to be eligible.

I also understand that I am responsible for paying all current and outstanding utility bills, including mortgage and rent.

I certify that the information on my application is true and correct to the best of my knowledge. I understand requesting disclosure of information is necessary to accomplish the purpose of the Human Services Program. Disclosure of this information is required. Failure to provide any information will result in this application not being processed. I certify that the information is not provided with the intent to commit fraud.

I certify that a representative from KCCSI has provided my household with information regarding child support.

I hereby acknowledge that the information related to determining my eligibility requires verification and documentation. By my signature, I authorize others to release such information as may be required for the determination of eligibility. I hereby consent to waive my right of confidentiality for the limited purpose of allowing KCCSI the opportunity to obtain information from all applicable parties to determine eligibility.

I also give permission to KCCSI to complete a follow up with me for up to 2 years from the date of approval.

Signature

Date

Intake Worker

Date



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PHONE 815-933-7883 * FAX 815-933-0635**



I, _____

**give the KCCSI staff permission to contact my landlord or mortgage company
in reference to my application.**

Landlord / Mortgage Company Name

Street Address

City, State, Zip Code

Landlord / Mortgage Company Phone Number

Applicant Signature

Date



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OPT-OUT FORM

I, _____, have been provided with the information concerning all programs. Below are the programs I will be applying for AND not applying for.

I understand that I can come back later to apply for services I opted out of on today.

| <u>Service</u> | <u>Interested</u> | <u>Opt-Out</u> |
|--|-------------------|----------------|
| <ul style="list-style-type: none"> Assistance with Rental Must have 5-day Eviction Notice (Excludes sub housing) | | |
| <ul style="list-style-type: none"> Assistance with Mortgage Must have Mortgage Arrears Statement | | |
| <ul style="list-style-type: none"> Assistance With Shelter Must be homeless | | |
| <ul style="list-style-type: none"> Weatherization Program | | |
| <ul style="list-style-type: none"> Assistance with Water and Sewer Must have a shut-off notice or shut off | | |
| <ul style="list-style-type: none"> ComEd Hardship Must Meet Hardship Requirements Eligible to apply every 2 years, if approved | | |
| <ul style="list-style-type: none"> Emergency Furnace Must be the homeowner and approved for LIHEAP | | |
| <ul style="list-style-type: none"> PIPP Must have ALL documents at the time of application | | |
| <ul style="list-style-type: none"> LIHEAP Gas assistance only Electric assistance only | | |
| | | |
| <ul style="list-style-type: none"> SCSEP Must be 55+ and unemployed | | |
| <ul style="list-style-type: none"> Child Support Information regarding how to apply for child support services in Illinois | | |

Client: _____

Date: _____

Intake Worker: _____

Date: _____