



Pat Brister
Parish President

St. Tammany Parish Government

Department of Health & Human Services

Community Action Agency

P. O. Box 1629

Slidell, LA 70458

Phone: (985) 646-2090

Fax: (985) 643-5843

CAA@stpgov.org

- Prior to completing an application you **must** contact St. Tammany Parish Community Action Agency for an appointment. (985-646-2090)
- All of your answers must be complete and honest.
- If you knowingly give false information or intentionally fail to report required information, you may be ineligible for services.
- During your scheduled appointment the CAA worker will explain the program rules and help you complete any parts of the application that you have not filled out.
- The CAA worker will also ask you for proof of certain information you have given.
- Ask the worker to explain anything you don't understand. Please note that completing an application does not guarantee services and all applications are subject to program eligibility and funding.

I acknowledge that I have read and agree to the above terms and conditions:

Signature



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**EMERGENCY SOLUTIONS GRANT PROGRAM
CLIENT INTAKE FORM**

Social Security Number _____ **Date:** _____

Last Name: _____ **First Name:** _____

Address: _____

City: _____ **Zip Code** _____

Telephone Number: _____ **Cell:** _____

MARITAL STATUS:

Single (Never Married) Married Separated Divorced Widowed

Chronically Homeless: Y N

Sex: Male Female

Ethnicity: Hispanic Non-Hispanic

Race:

- Asian
- Black/African American
- American-Indian/Alaskan () White
- Pacific Islander
- Other

Last Permanent Address (Last place resided for 90 or more days)

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____



An Equal Opportunity-Affirmative Action Employer- Equal Housing Opportunity-Handicap Accessible
Auxiliary Aids and Service are available up request to individuals with disabilities, TTY 1-800-846-5277
520 Old Spanish Trail, Suite 3C, Slidell, LA 70458





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Housing Status:

- Literally homeless
- Housed and at imminent risk of losing housing
- Housed and at-risk of losing housing
- Stably housed

Last Night's Residence:

- Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- Transitional housing for homeless persons (including homeless youth)
- Permanent housing for formerly homeless persons (such as SHP, S+C, or SRO Mod Rehab)
- Psychiatric hospital or other psychiatric facility
- Substance abuse treatment facility or detox center
- Hospital (non-psychiatric)
- Jail, prison or juvenile detention facility
- Rental by client, no housing subsidy
- Owned by client, no housing subsidy
- Staying or living in a family member's room, apartment or house
- Staying or living in a friend's room, apartment or house
- Hotel or motel paid for without emergency shelter voucher
- Foster care home or foster care group home
- Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside); inclusive of "non-housing service site (outreach programs only)"
- Other
- Safe Haven
- Rental by client, with VASH housing subsidy
- Rental by client, with other (non VASH) housing subsidy
- Owned by client, with housing subsidy

Length of Stay (in last night's residence): (Check One)

- One week or less
- More than one week, but less than one month
- One to three months
- More than three months, but less than a year
- One year or longer



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Family Type: (Check One)

- Single/Unaccompanied Female
- Single/Unaccompanied Male
- Female w/ children
- Male w/ children
- Couple w/o children
- Couple w/ children

- Veteran:** Y N
Domestic Violence: Y N
Disabling Condition: Y N
Authorization Y N

Special Needs: Check ONE answer for each criterion

Substance abuse Alcohol abuse Drug abuse Both alcohol and drug abuse
 Don't know Refused

- | | | | | |
|-----------------------------------|-----------------------------|------------------------------|-------------------------------------|----------------------------------|
| Physical disability | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Don't know | <input type="checkbox"/> Refused |
| Mental illness | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Don't know | <input type="checkbox"/> Refused |
| Illiterate or marginally literate | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Don't know | <input type="checkbox"/> Refused |
| HIV/AIDS and related diseases | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Don't know | <input type="checkbox"/> Refused |
| Domestic violence | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Don't know | <input type="checkbox"/> Refused |
| Developmental disability | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Don't know | <input type="checkbox"/> Refused |
| Chronic Health Condition | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Don't know | <input type="checkbox"/> Refused |

Income Information

Household Financial Resources:

Income received from any source in past 30 days? () No () Yes () Don't Know () Refused

Income Sources and Amount	Yes/No	Amount	Date Started	Whose Income?
<input type="checkbox"/> Earned Income:	<input type="checkbox"/> Y <input type="checkbox"/> N	_____ / _____ / _____	_____ / _____ / _____	_____
<input type="checkbox"/> Unemployment Insurance:	<input type="checkbox"/> Y <input type="checkbox"/> N	_____ / _____ / _____	_____ / _____ / _____	_____
<input type="checkbox"/> Supplemental Insurance Security (SSI)	<input type="checkbox"/> Y <input type="checkbox"/> N	_____ / _____ / _____	_____ / _____ / _____	_____
<input type="checkbox"/> Social Security Disability Income (SSDI)	<input type="checkbox"/> Y <input type="checkbox"/> N	_____ / _____ / _____	_____ / _____ / _____	_____
<input type="checkbox"/> Veteran Disability Payment	<input type="checkbox"/> Y <input type="checkbox"/> N	_____ / _____ / _____	_____ / _____ / _____	_____
<input type="checkbox"/> Private Disability Insurance	<input type="checkbox"/> Y <input type="checkbox"/> N	_____ / _____ / _____	_____ / _____ / _____	_____
<input type="checkbox"/> Workers Comp	<input type="checkbox"/> Y <input type="checkbox"/> N	_____ / _____ / _____	_____ / _____ / _____	_____



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- Temporary Assistance for Needy Families Y N _____/_____/_____
- General Assistance Y N _____/_____/_____
- Retirement Income from SS Y N _____/_____/_____
- Veteran's Pension Y N _____/_____/_____
- Pension from former job Y N _____/_____/_____
- Child Support Y N _____/_____/_____
- Alimony or other special support Y N _____/_____/_____
- Other source Y N _____/_____/_____

Total Monthly Income _____

Non-Cash Benefits

Non-Cash Benefits received from any source in past 30 days: Y N Don't Know Refused

Source of Non-Cash Benefit :

- Supplemental Nutrition Assistance Program (SNAP) Y N
- Medicaid Health Insurance Program Y N
- Medicare Health Insurance Y N
- State Children's Health Insurance Y N
- Special Supplemental Nutrition for Women, Infants
And Children Y N
- Veterans Administration (VA) Medical Services Y N
- TANF Child Care Services Y N
- TANF Transportation Y N
- Other TANF funded services Y N
- Section 8, public housing, or other ongoing rental assistance Y N
- Other Source Y N
- Temporary Rental Assistance Y N
- Don't Know Y N
- Refused Y N

Total Monthly Benefits _____





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***HOUSEHOLD MEMBERS: Record income, benefit information AND special needs in HMIS for EACH member of the household.**

Household Members Information

(1) Relationship to Head of Household: _____

Last Name: _____ First Name: _____ Middle Initial : _____

Date of Birth: ___/___/___ Sex: Male Female Ethnicity: Hispanic Non-Hispanic

Race: _____ Veteran: Y N Disabled: Y N

Last Permanent Address: mark one: Same as head of household Different from head of household

(If different from Head of Household list below)

Street Address: _____

City: _____ **State:** _____ **Zip** _____

SSN #: _____

If this is a minor child, do you have legal custody or guardianship of him/her? Yes No

[Documentation will be requested.]

(2) Relationship to Head of Household: _____

Last Name: _____ First Name: _____ Middle Initial : _____

Date of Birth: ___/___/___ Sex: Male Female Ethnicity: Hispanic Non-Hispanic

Race: _____ Veteran: Y N Disabled: Y N

Last Permanent Address: mark one: Same as head of household Different from head of household

(If different from Head of Household list below)

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

SSN #: _____

If this is a minor child, do you have legal custody or guardianship of him/her? Yes No

[Documentation will be requested.]

(3) Relationship to Head of Household: _____

Last Name: _____ First Name: _____ Middle Initial : _____

Date of Birth: ___/___/___ Sex: Male Female Ethnicity: Hispanic Non-Hispanic

Race: _____ Veteran: Y N Disabled: Y N

Last Permanent Address: mark one: Same as head of household Different from head of household

(If different from Head of Household list below)

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

SSN #: _____

If this is a minor child, do you have legal custody or guardianship of him/her? Yes No

[Documentation will be requested.]



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(4) Relationship to Head of Household: _____
 Last Name: _____ First Name: _____ Middle Initial : _____
 Date of Birth: ___/___/___ Sex: Male Female Ethnicity: Hispanic Non-Hispanic
 Race: _____ Veteran: Y N Disabled: Y N
 Last Permanent Address: mark one: Same as head of household Different from head of household
 (If different from Head of Household list below)
Street Address: _____
City: _____ **State:** _____ **Zip:** _____
SSN #: _____
 If this is a minor child, do you have legal custody or guardianship of him/her? Yes No
 [Documentation will be requested.]

(5) Relationship to Head of Household: _____
 Last Name: _____ First Name: _____ Middle Initial : _____
 Date of Birth: ___/___/___ Sex: Male Female Ethnicity: Hispanic Non-Hispanic
 Race: _____ Veteran: Y N Disabled: Y N
 Last Permanent Address: mark one: Same as head of household Different from head of household
 (If different from Head of Household list below)
Street Address: _____
City: _____ **State:** _____ **Zip:** _____
SSN #: _____
 If this is a minor child, do you have legal custody or guardianship of him/her? Yes No
 [Documentation will be requested.]

(6) Relationship to Head of Household: _____
 Last Name: _____ First Name: _____ Middle Initial : _____
 Date of Birth: ___/___/___ Sex: Male Female Ethnicity: Hispanic Non-Hispanic
 Race: _____ Veteran: Y N Disabled: Y N
 Last Permanent Address: mark one: Same as head of household Different from head of household
 (If different from Head of Household list below)
Street Address: _____
City: _____ **State:** _____ **Zip:** _____
SSN #: _____
 If this is a minor child, do you have legal custody or guardianship of him/her? Yes No
 [Documentation will be requested.]



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Please read carefully and sign:

CERTIFICATION OF TRUE AND CORRECT INFORMATION

“You will be subject to criminal prosecution under title 18 of the U.S. code if you knowingly, give false, incorrect, or incomplete information during this application process in order to obtain assistance”

Failure shall result to forfeiture or ineligibility and in termination of service and the repayment of such services. I understand proof of all statements may be required and I give permission to St. Tammany Parish Community Action to contact the appropriate public or private sources for verification and exchange of information. An appeal of a decision may be requested if it is considered unfair or if there has been a violation of civil rights.

THIS AGENCY DOES NOT DISCRIMINATE BECAUSE OF RACE, RELIGION, SEX, NATIONAL ORIGIN OR DISABILITY.

APPLICANT’S SIGNATURE: _____ DATE: _____

CAA REPRESENTATIVE SIGNATURE: _____ DATE: _____



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Minimum Required Documentation

- **Picture ID or Driver's License** for everyone in the household who is 18 years or older.
- **Social Security Cards** for every member of the household.
- **Birth Certificates** for all children 5 years old and younger; birth letters from hospital or shot records are also permitted.
- **Food Stamp Printout** *if applicable*, the most current food stamp letter. You can obtain this printout on the LACAFE portal website.
- **Lease** *if applicable*.
- **Verification of homelessness** *if applicable*, agency referrals or eviction notice.
- **Proof of Unearned Income**
 - 2015 Social Security/SSI Award Letter. (MUST SHOW YOUR MONTHLY INCOME).
 - 2015 Monthly Pension statement
 - Contribution form (this form may be picked up from our office and filled out by anyone who contributes financially to your household)
 - Unemployment statement
- **Proof of Earned Income**
 - Last 4 CURRENT and CONSECUTIVE paycheck stubs. If you cannot find the last 4 check stubs you can obtain an Employment Verification Form from our office that your employer may fill out.
 - If you have just started employment you must pick up an employment verification form from our office and have your employer fill out.
- If claiming **NO INCOME** you must provide proof of how you are maintaining.
- **Self-Employment applicants** must provide their current Federal Income Tax Returns with invoices, schedules, and receipts for work performed. MUST have filed most recent taxes.

INCOME MUST BE REPORTED FOR ANYONE 18 OR OLDER LIVING IN THE HOUSEHOLD
ALL DOCUMENTATION IS REQUIRED AT THE TIME OF APPOINTMENT

ADDITIONAL DOCUMENTS MAY BE REQUIRED.