

OUR MISSION:

To utilize and provide resources that assist people in need to obtain economic stability, ultimately creating a better way of life.

DISCLAIMER:

Applicants may not be excluded from program participation, be denied program benefits, or otherwise be discriminated against based on race, religion, sexual orientation, national origin, disability, cultural heritage, political beliefs or marital status.

AUTHORIZATION:

- ☐ This information is, to the best of my knowledge, true and complete. I understand that by signing this application, I give the agency the authority to verify the information provided on the application.
- ☐ I/We hereby authorize Springfield Partners for Community Action to release/exchange information from my records in order to assist me in resolving my situation. This information will be released only to those institutions, companies, agencies and funding sources that our organization believes can provide assistance in helping me.
- ☐ I authorized Springfield Partners for Community Action, Inc. to use my photograph/video for promotional and marketing purposes.
- ☐ I would like to receive periodic updates and newsletters via e-mail from Springfield Partners.

Applicant Name (Print):

Signature:

Date:

HOW DID YOU HEAR ABOUT US _____

For Office Use Only:

Program Name:	Employee Name:	Date Completed:	Date Entered:	Customer ID: (Database)

APPLICANT INFORMATION: INTAKE MUST BE COMPLETED TO BE CONSIDERED FOR SERVICES

Applicant's Name:				Date of Birth ____/____/____	
Home Phone #:		Cell Phone#	Work Phone#	Email Address:	
Home Address (include apt#)			City/Town	State	Zip Code
Mailing Address: (If different from above)			City/Town	State	Zip Code
Do You: <input type="checkbox"/> Own <input type="checkbox"/> Permanent housing <input type="checkbox"/> Other					
<input type="checkbox"/> Rent <input type="checkbox"/> Homeless					

Language spoken: _____

DEMOGRAPHIC INFORMATION:

Gender : <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Race: <input type="checkbox"/> Amer. Indian/Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hawaiian or Pacific <input type="checkbox"/> White <input type="checkbox"/> Multi-Race <input type="checkbox"/> Other	Household Type: <input type="checkbox"/> Single Person <input type="checkbox"/> Two Adults No Children <input type="checkbox"/> Single Parent <input type="checkbox"/> Two Parent <input type="checkbox"/> Non-Related Adults with Children <input type="checkbox"/> Multigenerational Household	Education Level: <input type="checkbox"/> Grade 0-8 <input type="checkbox"/> Grades 9-12 (non - graduate) <input type="checkbox"/> High School Graduate/Equivalent <input type="checkbox"/> 12+ & Some <input type="checkbox"/> 2 or 4 year College <input type="checkbox"/> College Graduate
Ethnicity: <input type="checkbox"/> Hispanic, Latino, or Spanish <input type="checkbox"/> Not Hisp., Latino, or Spanish			

HEALTH INSURANCE INFORMATION:

Do you have Health Insurance?		Do you have a disabling condition:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes please indicate type:			
<input type="checkbox"/> Medicaid	<input type="checkbox"/> State Children's Health Ins. Program	<input type="checkbox"/> Military Health Ins.	
<input type="checkbox"/> Medicare	<input type="checkbox"/> State Health Ins. for Adults	<input type="checkbox"/> Direct Purchase	
<input type="checkbox"/> Employment			

WORK STATUS FOR INDIVIDUALS OVER (18+):

<input type="checkbox"/> Employed Full Time	<input type="checkbox"/> Unemployed (Short Term, 6 months or less)	<input type="checkbox"/> Retired
<input type="checkbox"/> Employed Part Time	<input type="checkbox"/> Unemployed (Long Term, more than 6 months)	<input type="checkbox"/> Migrant Seasonal Farm Worker
<input type="checkbox"/> Unemployed (Not in labor force)		

HOUSEHOLD PRIMARY SOURCE OF INCOME - WEEKLY INCOME : \$ - MONTHLY INCOME : \$

<input type="checkbox"/> Employment Only	<input type="checkbox"/> Employment Other	<input type="checkbox"/> Employment and Non-cash benefits
<input type="checkbox"/> Employment and Other	<input type="checkbox"/> Employment, Other and None-Cash	<input type="checkbox"/> Income and Non-Cash Benefit

HOUSEHOLD OTHER INCOME SOURCES:

<input type="checkbox"/> SSI - Supplemental Security Income	<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> TANF
<input type="checkbox"/> SSDI - Social Security Disability Insurance	<input type="checkbox"/> Retirement	<input type="checkbox"/> Pension
<input type="checkbox"/> VA Services Connected Disability	<input type="checkbox"/> Income from Social Security	<input type="checkbox"/> Child Support
<input type="checkbox"/> VA Non-Service Connected Disability	<input type="checkbox"/> Unemployment Insurance	<input type="checkbox"/> EITC
<input type="checkbox"/> Private Disability Insurance	<input type="checkbox"/> Alimony or other Spousal Support	<input type="checkbox"/> Other

HOUSEHOLD NON-CASH BENEFITS:

<input type="checkbox"/> SNAP	<input type="checkbox"/> HUD VASH	<input type="checkbox"/> Permanent Supportive Housing
<input type="checkbox"/> WIC	<input type="checkbox"/> Public Housing	<input type="checkbox"/> Childcare Voucher
<input type="checkbox"/> LIHEAP	<input type="checkbox"/> Housing Choice Voucher	<input type="checkbox"/> Affordable Care Act Subsidy
<input type="checkbox"/> Other _____		

MILITARY INFORMATION: (FOR MILITARY PERSONNEL ONLY)

Military Status: <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> Not in Military	Type of Discharge (if applicable): <input type="checkbox"/> Honorable <input type="checkbox"/> General <input type="checkbox"/> Dishonorable <input type="checkbox"/> BCD <input type="checkbox"/> Medical <input type="checkbox"/> Other	Service Era (if applicable): <table style="width:100%;"> <tr> <td><input type="checkbox"/> WWII</td> <td><input type="checkbox"/> Peace Time</td> <td><input type="checkbox"/> Persian Gulf</td> </tr> <tr> <td><input type="checkbox"/> Vietnam</td> <td><input type="checkbox"/> Iraq</td> <td><input type="checkbox"/> Afghanistan</td> </tr> <tr> <td><input type="checkbox"/> Grenada</td> <td><input type="checkbox"/> Korea</td> <td><input type="checkbox"/> Other (please Indicate):</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Lebanon</td> <td></td> </tr> </table>	<input type="checkbox"/> WWII	<input type="checkbox"/> Peace Time	<input type="checkbox"/> Persian Gulf	<input type="checkbox"/> Vietnam	<input type="checkbox"/> Iraq	<input type="checkbox"/> Afghanistan	<input type="checkbox"/> Grenada	<input type="checkbox"/> Korea	<input type="checkbox"/> Other (please Indicate):		<input type="checkbox"/> Lebanon	
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<input type="checkbox"/> Grenada	<input type="checkbox"/> Korea	<input type="checkbox"/> Other (please Indicate):												
	<input type="checkbox"/> Lebanon													

(2)

BENEFITS FROM: OTHER ADULTS HOUSEHOLD MEMBER: INDIVIDUALS (18+)

Other Adult Name:

Date of Birth

Relationship to Applicant:

Primary Phone:

Email Address:

DEMOGRAPHIC INFORMATION:**Gender :**

- ☐ Male
☐ Female
☐ Other

Race:

- ☐ Amer. Indian/Alaskan
☐ Asian
☐ Black or African American
☐ Hawaiian or Pacific
☐ White
☐ Multi-Race
☐ Other

Education Level:

- ☐ Grade 0-8
☐ Grades 9-12 (non -graduate)
☐ High School Graduate/Equivalent
☐ 12+ & Some
☐ 2 or 4 years college
☐ College Graduate

Ethnicity:

- ☐ Hispanic, Latino, or Spanish
☐ Not Hispanic, Latino, or Spanish

HEALTH INSURANCE INFORMATION:

Do you have Health Insurance?

- ☐ Yes
☐ No

Do you have a disabling condition:

- ☐ Yes
☐ No

If yes please indicate type:

- ☐ Medicaid
☐ Medicare
☐ Employment
☐ State Children's Health Ins. Program
☐ State Health Ins. for Adults
☐ Military Health Ins.
☐ Direct Purchase

CHILDREN UNDER 18 INFORMATION

Child Name	DOB	Relationship	Gender (M/F/O)	RACE (see codes below)	Ethnicity (see codes below)	Education Level (see codes below)	Health Insurance (Y/N)	Type of Insurance (see codes below)	Disable (Y/N)

Use these codes to fill out the above chart:

Race:

- A. Amer. Indian/Alaskan
B. Asian
C. Black or African American
D. Hawaiian or Pacific
E. White
F. Multi-Race
G. Other

Ethnicity:

- A. Hispanic, Latino, or Spanish
B. Not Hispanic, Latino or Spanish

Education:

- A. Grade 0-8
B. Grade 9-12 (non-graduate)
C. High School Graduate/Equivalent
D. 12th grade & Some

Insurance

- A. Medicaid
B. Medicare
C. State Child Ins.
D. Other _____

Please let us know if you need to add additional household members.

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Springfield Partners for Community Action, Inc.

List of Our Departments, Programs & Services

Phone: 413-263-6500

Telephone Extensions

ASSET DEVELOPMENT DEPARTMENT

PROGRAMS:

✦ Credit Counseling	6567
✦ Financial Literacy Education	6567
✦ Low-Income (LITC) Taxpayers Clinic	6566
✦ Volunteer Income (VITA) Tax Assistance	6001

HOUSING & ENERGY DEPARTMENT

PROGRAMS:

✦ Emergency Fuel Assistance	6518
✦ Energy Conservation (Weatherization)	6576
✦ Eviction Clinic	6567
✦ Housing Counseling	6545

VETERAN'S DEPARTMENT

6591

SERVICES:

- ✦ Emergency Transportation Assistance
- ✦ V.A Benefits Claims Assistance
- ✦ Education and Employment Assistance

YOUTH & EDUCATION DEPARTMENT

6520

PROGRAMS:

- ✦ New Beginnings Early Education and Care Center
- ✦ Scholarship

OUR PROGRAMS

Asset Development Services

Credit Counseling
Financial Literacy Workshops
Low Income Taxpayer
Clinic (LITC)
Volunteer Income Tax
Assistance (VITA)

Housing & Energy Services

Emergency Fuel Assistance
Energy Conservation
(Weatherization)
Eviction Clinic
Housing Counseling

Veterans' Services

Education/Employment
Assistance
Emergency Transportation
Assistance
V.A. Benefits Claims
Assistance

Youth & Family Services

Multicultural
Alzheimer's Program
New Beginnings Early
Education & Care Center
Scholarship Program

MISSION STATEMENT

To utilize and provide
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Emergency Fuel Fund – File Checklist

File #: _____

Appointment Date: _____

Time: _____

Please bring the following required documentation to your appointment. Missing documents may delay your application and result in your appointment rescheduled.

1. Current Photo Identification
2. Statement of Hardship (in your words)
3. Utility Bill (for gas only. Must be current within 30-days and in applicants name):
 - a. Gas
4. Housing Status (Must be current within 30-days and in applicant's name).
NOTE: You only need to provide ONE item from the list, not ALL
 - a. Mortgage Statement
 - b. Rental Agreement
 - c. Lease
 - d. Property Tax Bill
 - e. Water/Sewer Bill
 - f. Homeowners Insurance
5. Income verification (bring all that apply to your household):
 - a. 4-Most recent consecutive pay stubs
 - b. Previous year tax returns
 - c. Pension/Retirement
 - d. Unemployment
 - e. Workers Compensation Benefits
 - f. Veterans Benefits
 - g. Alimony/Child Support (court order)
 - h. TNAF
 - i. Social Security Disability (SSDI)
 - j. Social Security (SSI)
 - k. SNAP
 - l. Rental Income
 - m. Other: _____

OUR PROGRAMS

Asset Development Services

Credit Counseling
Financial Literacy Workshops
Low Income Taxpayer
Clinic (LITC)
Volunteer Income Tax
Assistance (VITA)

Housing & Energy Services

Emergency Fuel Assistance
Energy Conservation
(Weatherization)
Eviction Clinic
Housing Counseling

Veterans' Services

Education/Employment
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File #: _____

STATEMENT OF DISCLOSURE

To all participants engaged in Housing Counseling Program and related services.

- Springfield Partners for Community Action has been a HUD-certified Housing Counseling Agency since 2002;
- Springfield Partners for Community Action has achieved the CHAPA Massachusetts Homeownership Collaborative Seal of Approval, effective through 2020;
- Springfield partners for Community Action is authorized to deliver the Frame Works online homebuyers education course;
- Springfield Partners for Community Action does not recommend any lending product, lenders, realtors, insurance, or any other goods, services or vendors to participants;
- Participants will be provided with materials and information regarding affordable homeownership, rental housing, lending products, and other types of assistance that are related to their counseling and/or action plan;
- At no time will participants be expected to or urged to use any specific goods, services, or vendors they learn about through this program;
- Participants in Springfield Partners for Community Action counseling and other services are encouraged to explore all available products, services and means of assistance;
- Participants are informed that they are not under any **Obligation** to utilize any information or services they receive during the course of this program;
- Participants are required to attend two one-on-one counseling sessions with the Housing Counselor. A Certificate of Completion will be issued at the conclusion of the final counseling session.

Paul F. Bailey

Paul F. Bailey, Executive Director

Date

Participants Signature

Date

HELPING PEOPLE. CHANGING LIVES.

OUR PROGRAMS

Asset Development Services

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Financial Literacy Workshops
Low Income Taxpayer
Clinic (LITC)
Volunteer Income Tax
Assistance (VITA)

Housing & Energy Services

Emergency Fuel Assistance
Energy Conservation
(Weatherization)
Eviction Clinic
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Veterans' Services

Education/Employment
Assistance
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Assistance
V.A. Benefits Claims
Assistance

Youth & Family Services

Multicultural
Alzheimer's Program
New Beginnings Early
Education & Care Center
Scholarship Program

File #: _____

Participant Authorization for Release/Share of Information

I/we _____, do give
premission to Springfield Partners for Community Action (Springfield Partners)
staff authorization to obtain and/share information and documentation necessary
to determine my eligibility for services provided by Springfield Partners and its
partner organizations for the purpose of providing comoprehensive services.

This informtion and documentation may include but not limited to basic contact
information, credit reports, employment histiry, rental history, income and asset
verification, bank statements and other financial records as may be required.

This authorization expired in 1-year from the date of signature (s), unless
otherwise extended in writing by the participant (s).

**I have read and understand the above information. A copy has been
provided to me.**

MISSION STATEMENT

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Participant Signature

Date

Co-Applicant

Date

Agency Representative/Staff

Date

SPRINGFIELD PARTNERS

for Community Action

HOUSEHOLD INCOME/DEMOGRAPHIC VERIFICATION

The funder requires that we collect and provide the information contained within this form for each person we assist.

All information MUST be completed. **Please be sure to fill in the information on the reverse side.**

GENERAL INFORMATION

Name: _____ Application#: _____

Address: _____ Apt#: _____

City, Zip: _____

DEMOGRAPHIC INFORMATION (This information is used for reporting purposes only)

IMPOTANT: Funder requires information for both ethnicity (#1 below) and race (#2 below). Please answer numbers 1-3. DO NOT LEAVE BLANK.

1. _____ Hispanic/Latino _____ Not Hispanic/Latino

2. Ethnicity/Race:

____ American Indian/Alaskan Native

____ Multi – Race

____ Asian

____ Other

____ Black/African American

____ Hawaiian or Pacific Islander

____ White

3. Are you a female-headed household? _____ Yes _____ No

Continue on other side



INCOME INFORMATION (Household MUST not exceed 200% of FPL)

Instructions:

- ❖ Circle your household size
- ❖ Circle the appropriate household income. To be eligible for services, household income **MUST** meet the appropriate annualized income as identified below.
- ❖ 2019 Federal Poverty Guidelines (source, HHS Poverty Guidelines)

<u>HOUSEHOLD SIZE</u>		<u>HOUSEHOLD INCOME</u>	
<u>Number in household</u>		<u>Maximum household income (annualized)</u>	
1 person		\$24,280	
2 persons		\$32,920	
3 persons		\$41,560	
4 persons		\$50,200	
5 persons		\$58,840	
6 persons		\$67,480	
7 persons		\$76,120	
8 persons		\$84,760	

For each additional person, add \$10,400

Certification

I/We certify that the information contained herein is true, complete and accurate to the best of my/our knowledge and belief. I/We grant permission to Springfield Partners for Community Action, Inc., its agents and partners to obtain any additional information deemed necessary to determine my/our eligibility for services offered by Springfield Partners for Community Action, Inc., its agents and partners.

Applicants Signature: _____ Date: _____

Print Name: _____

Co-Applicant: _____ Date: _____

Print Name: _____



HELP PAY HEATING (GAS) BILLS?

**ON SITE APPLICATION ACCEPTED AT 100 ELM ST.
TUESDAY, SEPTEMBER 17TH FROM 10 AM-2 PM!**

WE ARE ABLE TO ASSIST
ANYONE WITH AN INCOME
OF **UP TO 80% OF THE
STATE FEDERAL INCOME.**

80% OF STATE MEDIAN INCOME	
HOUSEHOLD	INCOME
1	Up to \$47,346
2	Up to \$61,916
3	Up to \$76,484
4	Up to \$91,052
5	Up to \$105,620
6	Up to \$120,188
7	Up to \$122,919
8	Up to \$125,651

We service these areas:

*Springfield, East Longmeadow, Longmeadow, Agawam, Southwick, Granville, Tolland,
Blandford, Chester, Montgomery, Russell, Westfield, West Springfield, Holyoke,
Chicopee, Granby, Ludlow, Wilbraham, Hampden, Mons●n, Palmer, Brimfield, Holland
& Wales.*

Funding provided by a grant received from the Massachusetts Attorney General's Office.