Community Action Partnership

CAP CARES Program

Overview

The CAP CARES Program is a CSBG funded program to assist Riverside County families with emergency assistance to help cover unmet household bills such as water, sewage, garbage, utility assistance, technology and special needs.

Program Eligibility

Income-qualification is based on 200% of the Federal poverty guidelines and the number of people in the household.

2020 CSBG CARES Act Poverty Guidelines

Size of Family Unit or Number in Household	Monthly Income	Annual Income
1	$2,127	$25,520
2	$2,873	$34,480
3	$3,620	$43,440
4	$4,367	$52,400
5	$5,113	$61,360
6	$5,860	$70,320
7	$6,607	$79,280
8	$7,353	$88,240
9+	Add $4,480 for each person over 8	

Participant Requirements

Reside in Riverside County
Be 18+ years old
Submit a form of identification (government issued ID, consular identification card, or passport)
Copy of current bills. (No older than 4 weeks).

Application Process

1. Submit CAP Cares application, intake sheet, identification and a copy of the current utility bill(s) you are requesting assistance with. Eligible bills include water, trash, sewer, electric, propane, internet.

2. Once your application has been reviewed and approved, an official award letter will be provided to confirm the payment. Communicate with company, to inform them that all program requirements under the CAP CARES Program have been met and a payment will be made on your behalf. Please note that the payment will made directly to the company.

3. A Community Action staff representative may contact you, as a courtesy follow-up and wellbeing check of you and your family during COVID-19. Regular follow-ups may take place for the duration the recovery period through May 2022.

Assistance based on availability of funds

Community Action Cares

Intake Application

Section 1 Applicant Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Social Security #: _____ Date of Birth: _____ Phone: _____

Email: _____ How did you hear about CAP: _____

Which service/services would you require assistance for: Utilities: ☐ Technology: ☐ Other: _____

Section 2 Household

Total number of persons living in household including applicant: _____

**Please include separate sheet for additional household members*

Full Name: _____

Relationship to Client: _____ Age: _____

Full Name: _____

Relationship to Client: _____ Age: _____

Full Name: _____

Relationship to Client: _____ Age: _____

Section 3 Applicant Signature

1. I hereby authorize the Community Action Partnership (CAP) to examine all employment, income, utility, and other records pertinent to my application for assistance.
2. I hereby authorize the release of information regarding my bills past and future, to CAP.
3. I certify under penalty of perjury that all information herein is true and correct to the best of my knowledge.
4. I agree to be contacted monthly to share information about the wellbeing of my family during COVID -19 and during the recovery period until May 2022.
5. I certify that the total household income for the above individual *does/does not* (circle one) exceed the established poverty guidelines indicated above.

Applicant Signature: _____ Date: _____ Witness Signature: _____

Agency Approval

Approved: Yes ☐ No ☐			
Amount: _____	Management Approval	Intake Staff Name (Print)	Date

Project Code Number:	

Customer Intake Form

CUSTOMER INFORMATION			
Last Name	First Name	Date of Birth	Today's Date
Phone ( )	Email	SSN	Office Location
Address	City		Zip Code

GENDER	MARITAL STATUS		ETHNICITY
☐ Male	☐ Single	☐ Separated	☐ Hispanic/Latino
☐ Female	☐ Married	☐ Divorced	☐ Non-Hispanic/Latino
☐ Other	☐ Domestic Partner	☐ Widowed	

INDICATE YOUR RACE (SELECT ONE)		
☐ American Indian/Alaskan Native	☐ Caucasian (White)	☐ Other
☐ Asian	☐ Hawaiian/Pacific Islander	☐ Unspecified
☐ Black/African American	☐ Multi-Race	

INDICATE YOUR EDUCATION (SELECT ONE)		
☐ 0-8th Grade	☐ 9-12 Education	☐ High School Graduate
☐ 12+ Some Postsecondary	☐ GED	☐ Unspecified
☐ 2 Year Degree	☐ Graduate Degree	☐ Vocational School
☐ 4 Year Degree		

INDICATE YOUR HEALTH INSURANCE (SELECT ONE)		
☐ No Health Insurance	☐ Medi-Cal	☐ State Children's Health Insurance
☐ Direct Purchase	☐ Medicare	☐ State Insurance for Adults
☐ Employment Based	☐ Military Health Care	☐ Unknown

MILITARY STATUS (SELECT ONE)	DO YOU RECEIVE FOOD STAMPS?	ARE YOU DISABLED?
☐ Active Military	☐ Yes	☐ Yes
☐ Veteran	☐ No	☐ No
☐ No Military	☐ Decline to Answer	☐ Decline to Answer

FARMER (SELECT ONE)	WORK STATUS (SELECT ONE)	
☐ Farmer	☐ Employed Full-Time	☐ Unemployed (Long-Term)
☐ Migrant	☐ Employed Part-Time	☐ Unemployed (Not in Workforce
☐ Migrant Seasonal	☐ Migrant Seasonal Farm Worker	☐ Unemployed Short Term >6mos
☐ Not a Farmer	☐ Retired	☐ Unknown

DO YOU RECEIVE WIC? (SELECT ONE)	NON-CASH BENEFITS (SELECT ONE)	
☐ Yes	☐ Affordable Care Act Subsidy	☐ LIHEAP
☐ No	☐ Childcare Voucher	☐ None
☐ Unknown	☐ Housing Choice Voucher	☐ Other
	☐ Public Housing	☐ Permanent Supportive Housing
	☐ CalFresh/Food Stamps	☐ WIC

INDICATE YOUR MONTHLY INCOME AMOUNT AND SELECT INCOME SOURCE:		$
☐ Employment	☐ Pension	☐ Social Security
☐ TANF	☐ Alimony	☐ Retirement Social Security
☐ Public Assistance	☐ Rental	☐ SSDI
☐ Child Support	☐ EITC	☐ SSI
☐ Self-Employment	☐ Work Comp	☐ VA Service - Disability
☐ Unemployment Insurance	☐ Private Disability Insurance	☐ VA Non-Service - Disability

HOUSING STATUS (SELECT ONE)		
☐ Rent	☐ Own - Mobile Home	☐ Runaway
☐ Own	☐ Other	☐ Temp Stable
☐ Own - Multi-Family	☐ Homeless	☐ Temp Unstable

Please complete this side of the form for any additional members of your household.

Customer Information					Using the key below please answer the following questions						Using (Y) for Yes or (N) for No please answer the following					Income	
First Name	Last Name	Date of Birth	Male or Female	Marital Status	Relation to Applicant	Ethnicity	Race	Education	Health Insurance	Served in Military	Food Stamps	WIC	Disabled	Farmer	Income	Source of Income

Marital Status	Relation to Applicant	Ethnicity	Race	Education	Health Insurance	Source of Income
A. Single B. Married C. Domestic Partner D. Divorced E. Separated	A. Brother B. Child C. Father D. Foster Child E. Foster Parent F. Friend G. Grandchild H. Grandparent I. Mother J. Other K. Other Related L. Other Relative M. Sister N. Spouse O. Stepfather P. Stepmother	A. Hispanic or Latino B. Non-Hispanic or Non-Latino	A. American Indian or Alaskan Native B. Asian C. Black/African American D. Caucasian (White) E. Hawaiian/Pacific Islander F. Multi-Race G. Other	*If household member is over age of 18 indicate highest grade completed* A. 0-8th grade B. 9-12th grade C. High School Grad D. GED E. 12 + some secondary school F. 2 -year College graduate G. 4-year College graduate H. N/C Child under age of 18	*Please indicate your source of Health Insurance* A. No Health Insurance B. Direct Purchase C. Employment Based D. Medical E. Medicare F. Military Health Care G. State Children's Health Insurance H. State Insurance for Adults I. Unknown	*Please indicate your source of income* A. Employment B. TANF C. Public Assistance D. Self-Employment E. Alimony F. Child Support G. Interest/Dividends H. Pension I. Rental J. Social Security K. SSDA L. SSI M. Veterans N. Work Comp