Mary B. Dolan Youth Assistance Fund

Dear Prospective Recipient:

We welcome your application to this program which, if approved, provides financial assistance to youth (young adults) **16-24 years of age** who were on their own at a young age (*abandoned, emancipated, aged out of foster care, or otherwise without a parent/guardian prior to the age of 21*). The maximum limit for fund requests is **$1,000 per year.** Although preference is given to requests to further education or advance job skills, funds are not limited to such requests. These applications are submitted to a committee who vote on the request, once a month.

Applications are due by 12:00pm on the last Wednesday of the month to ensure consideration for the upcoming month. Please ensure all required documentation accompanies this application when it is returned to Catholic Charities of Northern Kansas. Lack of documentation may result in a delay in the processing of the application and could cause the application to be passed over until the next month's review period.

Each application is considered on a case-by-case basis, though preference is to send the funds directly to the vendor.

The completion of this form does not guarantee approval for assistance. You will be notified directly of the committee's decision.

Required Documentation Includes the following:

- ☐ *Application, completed in full*
- ☐ *Proof of Income*
- ☐ *Copies of Any Bills/Items to be Paid with the Funds (if applicable)*
- ☐ *Documentation Related to Education/Job Skill Advancement (if applicable)*

If you have difficulty completing the form or gathering any of the documents listed above, please contact the office for assistance. You may return the completed application, with the accompanying documentation, to any of the Catholic Charities 3 locations.

THANK YOU!

Amanda Lohf
Stabilization Services Specialist
785-825-0208
alohf@ccnks.org

Mary B. Dolan Youth Assistance Fund

Application Date: _____

Person completing application: _____ Relationship: _____

Best contact phone number for person completing application: _____

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

Applicant Address: _____ City: _____

Zip Code:_____ County: _____ Applicant DOB: _____

Best Contact Phone Number: _____ Cell Home Work Message Only

At what age did the applicant start living *independently* without an adult?	**_____**	
Was the applicant ever on the truancy docket?	**YES**	**NO**
Was the applicant ever declared a CINC (child in need of care)?	**YES**	**NO**
Is the applicant currently, or has the applicant ever, been in foster care placement?	**YES**	**NO**
If yes, when and where? _____		
Was the applicant ever the child subject of a DCF investigation?	**YES**	**NO**
If yes, was it substantiated or unsubstantiated?	**_____**	

Please attach verifying documents or the statement of a person who can verify these facts as true.

Please provide background information about the applicant's situation:

_____

_____

_____

_____

_____

_____

If approved, how would you like the funds to be distributed?

_____

_____

_____

_____

Applicant Signature: _____ Date: _____

Interviewer Signature: _____ Date: _____

REMEMBER TO INCLUDE PROOF OF ALL HOUSEHOLD INCOME AND ALL DOCUMENTATION RELATED TO THE ASSISTANCE YOU ARE REQUESTING

Mary B. Dolan Youth Assistance Fund

OFFICE USE ONLY:

Initials of Staff Receiving Application: _____ Date: _____ Time: _____ AM / PM

_____ Proof of Income (130% Poverty Level) **_____Documentation of Illness**

_____ Documentation of Expenses to be Paid **_____ Agency Intake Form**

_____ Completed Application **_____ Completed Budget Form**

Staff Notes:

_____

_____

_____

_____

_____

For Case Manager Only:

Applicant Review Notes:

_____

_____

_____

_____

_____

Approval Date: _____ Amount Approved: _____

Denial Date: _____ Date Client Notified: _____

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CCNKS - STABILIZATION & OUTREACH SERVICES

PROGRAM APPLICATION BUDGET FORM - *MUST ACCOMPANY APPLICATION*

LAST NAME _____ FIRST NAME _____ DATE: _____

INCOME SOURCES & AMOUNTS FOR LAST 30 DAYS

☐ Earned Income	$_____	☐ General Assistance	$_____
☐ Unemployment Insurance	$_____	☐ Retirement Income from Social Security	$_____
☐ Supplemental Security Income (SSI)	$_____	☐ VA Non-Service Connected Disability	$_____
☐ Social Security Disability Income (SSDI)	$_____	☐ Pension from a Former Job	$_____
☐ VA Service Connected Disability Compensation	$_____	☐ Child Support	$_____
☐ Private Disability Insurance	$_____	☐ Alimony or other Spousal Support	$_____
☐ Worker's Compensation	$_____	☐ Other	$_____
☐ Temporary Assistance to Needy Families (TANF)	$_____	**TOTAL**	**$**_____

NON -CASH BENEFITS AND AMOUNTS CURRENTLY RECEIVING **Please check box even if amount is unknown.**

☐ SNAP/Food Stamps or money for food on a benefits card	$_____
☐ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	$_____
☐ TANF Child Care Services/Transportation Services/Other TANF Services	$_____
☐ Section 8, Public Housing, or Other Rental Assistance	$_____
☐ Other Source	$_____
☐ Temporary Rental Assistance	$_____
☐ Child Support	$_____
TOTAL	**$**_____

EXPENDITURE TYPES AND AMOUNTS FOR LAST 30 DAYS

☐ Rent/Mortgage	$_____	☐ Car Payment	$_____
☐ Electricity-Utility	$_____	☐ Gasoline (Vehicle)	$_____
☐ Gas/Heating Oil - Utility	$_____	☐ Insurance (Vehicle)	$_____
☐ Sewage/Trash	$_____	☐ Child Care (Personally Paid)	$_____
☐ Telephone-Home	$_____	☐Health Insurance (Personally Paid)	$_____
☐ Cell Phone	$_____	☐ Withholding Tax	$_____
☐ Water -Utility	$_____	☐ Fines/Tickets/Restitution Payments	$_____
☐ Food (Excluding Food Stamps)	$_____	☐ Other _____	$_____
☐ Medical (Dr. Copays/Prescriptions)	$_____	☐ Other _____	$_____
☐ Transportation (Bus Passes/Cabs/Uber	$_____	☐ Other _____	$_____
		TOTAL	**$**_____

TOTAL HOUSEHOLD INCOME AND NET INCOME

Household Income $ _____ Net Income $ _____

REASON FOR ASSISTANCE (Please only check the primary reason for requesting assistance)

☐ Not Working/Seeking Work	☐ Medical-Short/Long Term	☐ Caring for Sick/Disabled Family	☐ Fire
☐ Sudden Job Loss	☐ Eviction - Non-Payment	☐ Weather/Natural Disaster	☐ Crime Victim
☐ Release from Incarceration	☐ Property Condemned	☐ Unexpected Expense (non-medical)	☐ Homelessness
☐ Non-Livable Wage	☐ Moving/Newly Relocated	☐ Family Disruption	☐ Other

OUTSIDE FUNDS USED BY APPLICANT

☐ LIEAP	☐ Salvation Army	☐ Red Cross
☐ Local Social Service Agency	☐ Local Food Bank	☐ Church _____
☐ Project Deserve - Gas	☐ Women Helping Women (Salina Only)	☐ Direct Prescription Assistance
☐ Share The Warmth	☐ Other: _____	

RELEASE OF INFORMATION: I verify that the information I have provided above is true and correct. I consent to the release of pertinent information contained the spaces above to CCNKS as necessary to determine my eligibility and provide services applied for.

Applicant Signature: _____ Date: _____ Staff Signature: _____ Date: _____

CMH 11/2021

Mary B. Dolan Youth Assistance Fund

Agency Intake Form

PLEASE PRINT CLEARLY

Date:_____ **Returning Client:** YES NO **Check if Homeless:** ☐

CLIENT INFORMATION

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

Gender: Female / Male **Date of Birth:**_____ **Marital Status:**_____

Ethnic/Racial Background (circle): Native American African American Hispanic/Latino Asian/Pacific Biracial/Multiracial White Unknown Other:_____

Address:_____

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

Home #:_____ **Work #:**_____ **Cell #:**_____

Email:_____

Number Living in Household: _____ **TOTAL Monthly Household Income** $_____

Please circle all forms of income: Salary/Wages, Unemployment, Disability, Soc. Sec., Child Support, Pension, Other

Does anyone in the household receive public assistance? YES NO

If yes, circle all that apply: Housing, Cash Assistance, WIC, Food Stamps, Childcare Assistance, Reduced lunches

SPOUSE INFORMATION: If applicable

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

Gender: Female / Male **Date of Birth:**_____ **Marital Status**:_____

Ethnic/Racial Background (circle): Native American African American Hispanic/Latino Asian/Pacific Biracial/Multiracial White Unknown Other:_____

Is any member of the household currently serving in the military or a veteran? YES NO
Is any member of your household a veteran of the military? YES NO