KCM
KATY CHRISTIAN MINISTRIES

Documents Needed for Appointment

**Social Services Office Hours:**
**Mon – Thurs 9 AM – 4:15pm**
**Closed for lunch 12 PM – 1 PM**

**FINANCIAL ASSISTANCE IS LIMITED TO ONE TIME PER 12-MONTH PERIOD AND A MAXIMUM OF 3 TIMES IN A LIFETIME.**

## IDENTIFICATION:

- ☐ Current valid driver's license, passport, visa, Texas ID card, or employment ID for ALL adults in the household.
- ☐ Social Security card from at least one household member.
- ☐ Birth certificates, school registration record, or Award Letters for all children under the age of 18 years living in the household.
- ☐ Court-appointed guardianship papers when applicable.

****No child will be added to the file without proper documentation. ****

## PROOF OF ADDRESS & EXPENSES:

- ☐ CURRENT full lease agreement signed by client and leasing manager, mortgage statement, mobile lot agreement.
- ☐ Utility bills with current name and address (light, gas, water, etc.) ***If your name is not on the bill, then you must show proof of identification of the person whose name is on the bill.*
- ☐ Other bills (car note, car insurance, payday loans, etc.)

****Bills need to be in applicant's name, or a household member. ****

## INCOME:

- ☐ Last 30-day paystubs for each working adult in the household
- ☐ Social Security Award Letters or SSI Letters
- ☐ Worker's Compensation, Disability or Unemployment letter
- ☐ Proof of Child Support payments
- ☐ If anyone in the household is eighteen (18) years old or older and is not in school and not employed, proof of unemployment is needed.
- ☐ If unemployed, must show proof by being registered with Gulf Coast Careers/Texas Workforce Commission or have a disability. Proof of disability is needed from a doctor.

****If you are paid in cash, we will provide you with an employment verification letter which will need to be completed by your employer. ****

## ADDITIONAL INFORMATION:

- ☐ A bank statement of your last 30 days transactions of your checking/savings account
- ☐ Food Stamps letter (SNAP)
- ☐ Documentation of current situation. Ex: medical bills, discharge papers, pharmacy expenses, notice of loss of wages, disconnection notice, eviction notice, housing assistance, etc.

KCM Service Areas: 77449, 77493, 77494, 77450, 77476, 77406, 77407, 77441, 77423, 77094, 77084 (Katy ISD only)

**Your appointment with a case manager doesn't automatically ensure financial aid. Financial assistance is not guaranteed.
**Please allow 10 to 14 business days to process financial requests.
**Payments are made directly to creditor/landlord.

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DOCUMENTOS REQUERIDOS

**Horario de Servicios Sociales:**
**Lunes a jueves 9 AM – 4:15 PM**
**Cerrado 12 PM – 1 PM**

**LA ASISTENCIA FINANCIERA ESTÁ LIMITADA A UNA VEZ POR PERÍODO DE 12 MESES Y A UN MÁXIMO DE 3 VECES EN LA VIDA**

IDENTIFICACIÓN:

- ☐ Licencia de conducir, pasaporte, visa, tarjeta de identificación de Texas o identificación de empleo válida y vigente para TODOS los adultos del hogar.
- ☐ Tarjeta de Seguro Social de al menos un miembro del hogar.
- ☐ Certificados de nacimiento, registro de inscripción escolar o cartas de concesión de todos los niños menores de 18 años que viven en el hogar.
- ☐ Documentos de tutela designados por el tribunal cuando corresponda.

** Ningún niño será agregado al expediente sin la documentación adecuada. **

COMPROBANTE DE DIRECCIÓN Y GASTOS:

- ☐ Contrato de arrendamiento completo ACTUAL firmado por el cliente y el administrador de arrendamiento, estado de cuenta de la hipoteca, contrato de lote móvil.
- ☐ Facturas de servicios públicos con nombre y dirección actual (luz, gas, agua, etc.) **Si su nombre no aparece en la factura, deberá presentar prueba de identificación de la persona cuyo nombre aparece en la factura.
- ☐ Otras facturas (billete de automóvil, seguro de automóvil, préstamos de payday, etc.)

** Las facturas deben estar a nombre del solicitante o de un miembro del hogar. **

INGRESO:

- ☐ Recibos de sueldo de los últimos 30 días de cada adulto que trabaja en el hogar
- ☐ Cartas de concesión del Seguro Social o cartas de SSI
- ☐ Carta de compensación laboral, incapacidad o desempleo
- ☐ Comprobante de pagos de manutención infantil
- ☐ Si alguien en el hogar tiene dieciocho (18) años o más y no está en la escuela ni está empleado, se necesita prueba de desempleo.
- ☐ Si está desempleado, debe mostrar prueba de estar registrado en Gulf Coast Careers/Texas Workforce Commission o tener una discapacidad. Se necesita prueba de discapacidad de un médico.

** Si le pagan en efectivo, le proporcionaremos una carta de verificación de empleo que deberá completar su empleador. **

INFORMACIÓN ADICIONAL:

- ☐ Un extracto bancario de las transacciones de los últimos 30 días de su cuenta corriente/de ahorros
- ☐ Carta de Cupones para Alimentos (SNAP)
- ☐ Documentación de la situación actual. Por ejemplo: facturas médicas, papeles de alta, gastos de farmacia, aviso de pérdida de salario, aviso de desconexión, aviso de desalojo, asistencia de vivienda, etc.

Áreas de servicio de KCM: 77449, 77493, 77494, 77450, 77476, 77406, 77407, 77441, 77423, 77094, 77084 (solamente Katy ISD)

**Tu cita no garantiza automáticamente la ayuda económica. La asistencia financiera no está garantizada.
**Espere de 10 a 14 días hábiles para procesar las solicitudes financieras.
**Los pagos se realizan directamente al acreedor/propietario.

KATY CHRISTIAN MINISTRIES

| For Office Only (Appointment) |
|---|
| Date: |
| Time: |
| Apricot ID: |

Updated 8/26/2025

# Enrollment Form / Formulario de inscripción

Address / Dirección: _____

City State Zip Code

Email / Correo electrónico: _____ Telephone / Telefono: _____

Is this your first time at KCM? ¿Es su primera vez en KCM? Yes / No

Are you a U.S.A. Veteran or Surviving Spouse or dependent: YES / NO

Circle one: Rent / Mortgage

Circule uno: ¿Alquilas? / ¿Hipoteca?

How many bedrooms are in your home? _____

Cuantas recamaras hay en su casa? _____

Gender Identity: (Circle One)

Male Female Transgender

Race: (Circle One)

Black/African American White Multi-racial Hispanic/Latino

American Indian Asian

| Name of Head of Household / Nombre Cabeza del hogar: | | Date of Birth / Fecha de nacimiento: |
|---|---|---|
| | | |

**Household Members / Miembros del hogar**

| Name as shown on government ID / Nombre como se muestra en la identificación gubernamental | | Date of Birth / Fecha de nacimiento | Relationship to HOH / Relación al hogar |
|---|---|---|---|
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Are you currently employed? YES / NO

¿Está trabajando? SI / NO

What type of assistance are you looking for? _____

¿Qué tipo de asistencia estás buscando? _____

Briefly state why you are seeking assistance/Indique brevemente por qué busca ayuda.

_____

_____

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KCM Service Areas: 77449, 77493, 77494, 77450, 77476, 77406, 77407, 77441, 77423, 77094, 77084-Katy ISD only

Áreas de servicio de KCM: 77449, 77493, 77494, 77450, 77476, 77406, 77407, 77441, 77423, 77094, 77084-solamente Katy ISD

Your Appoinmtent Does Not Guarantee Assistance. Financial Assistance IS NOT Guranteed.

Tu Cita NO Garantiza Ayuda Financiera. La Asistencia Financiera No Esta' Garantizada.

# General Consent to Exchange Information & Authority to Act on Client's Behalf

*By completing this form, a client of Katy Christian Ministries will enable Katy Christian Ministries to liaise with nominated organizations and to act on their behalf in relation to inquiries and the intent to gather information to the extent of the authority given in this form. If you choose not to complete this form, Katy Christian Ministries can provide you with advice, but cannot act on your behalf. This form is to be completed by persons (clients) seeking services from Katy Christian Ministries.*

## Client Consent to exchange personal information

Katy Christian Ministries may be required to exchange information with different agencies; however, this does not give Katy Christian Ministries authority to act on your behalf with these agencies. By signing this form, you give Katy Christian Ministries the authority to exchange information with agencies on your behalf.

## Authority to Act on a Client's behalf

To provide you with services, Katy Christian Ministries needs to be able to act on your behalf with a number of agencies. We ask you to nominate the specific agencies you are authorizing Katy Christian Ministries to contact on Page 2 of this form. By doing so and signing this form, you authorize Katy Christian Ministries to act on your behalf when dealing with the third parties/agencies you have nominated on all matters including but not limited to:

- Enquiring on your behalf
- Acting and making changes on your behalf
- Receiving copies of correspondence

*Authorizing Katy Christian Ministries to act on your behalf does not take away your right to contact the nominated third party/agency.*

## General Information about Privacy

To provide you with a professional level of service, Katy Christian Ministries needs to collect personal information about you. At all times you have a right to have that personal information kept private and request a copy of all personal information recorded by Katy Christian Ministries. Katy Christian Ministries is bound by privacy and confidentiality laws that limit who can look at information about you and when it can be given out.

## Definitions

Client; any person, persons or agencies recorded on this form in the section headed "The Client".

- Katy Christian Ministries; any person or entity acting under the employment, subcontract or other authority Katy Christian Ministries
- Client nominated third party/agency; any person or agency recorded on this form in the section headed "Nominated Third Parties/Agencies".
- Exchange; means to request, collect, record, distribute or otherwise engage in the use of.
- Service/s; has the meaning as defined in the letter of engagement and/or the client service charter available on request from Katy Christian Ministries

## General Consent to Exchange Information & Authority to Act on Client's Behalf

NOTE: Your consent is not needed for the use, disclosure or exchange of personal information if required or authorized by law in some instances including but not limited to child protection, urgent health and lawful investigation situations.

### The Client

Full Name:

_____

Address:

_____

State: _____ Zip Code: _____ Phone: _____ Mobile: _____

Email: _____ DOB: _____/_____/_____

**Nominated Third Parties/Agencies**

This section gives Katy Christian Ministries the authority to act on your behalf with the agencies you nominate here.

| **Name or Description:** |
|---|
| |
| |
| |

### Authorization

I,_____ of _____,

(Full Name) (Address)

authorize Katy Christian Ministries to collect, exchange and keep record of, my personal information as is required by Katy Christian Ministries.

Further, I authorize Katy Christian Ministries to act on my behalf in any dealings with the Third Parties/Agencies I have nominated above, and to receive copies of all correspondence from the same.

I give this consent according to the provisions of this document and acknowledge that this authority will remain in force until I provide Katy Christian Ministries with written confirmation of my withdrawal of consent. I understand that it is my responsibility to inform Katy Christian Ministries if any of the details that I have provided in this form change.

Sign _____ Date _____

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KATY CHRISTIAN MINISTRIES

# HMIS Consent and Release

Use of a Homeless Management Information System (HMIS) is required by the US Department of Housing and Urban Development (HUD) for agencies that receive certain types of HUD funding. Other funding sources may also require program participation in HMIS. This system is not electronically connected to HUD and is only used by authorized agencies. All persons accessing HMIS have received confidentiality training and have signed agreements to protect clients' personal information and limit its use appropriately. The HMIS Privacy Policy is available upon request and is posted at the Coalition for the Homeless's website (www.homelesshouston.org/ HMIS). Any additional data sharing agreements, providing details on how the member agency handles client information beyond the baseline HMIS Privacy Policy, are available at the agency service sites.

I give permission to the agency listed below to collect and enter information into HMIS about me and my household, which may include demographics, picture, health information, and services that I receive from participating agencies.

I understand that the HMIS is shared with and used by authorized agencies in my community for the purposes of:

• Assessing clients' needs in order to provide better assistance and to improve their current or future situations

• Improving the quality of care and service for people in need.

• Tracking the effectiveness of community efforts to meet the needs of people who have received assistance. • Reporting data on an aggregate level that does not identify specific people or their personal information.

I understand that:

• I have the right to review my HMIS record with an authorized user.

• All agencies that use HMIS will treat my information with respect and in a professional and confidential manner.

• Unauthorized people or organizations cannot gain access to my information without my consent.

• If I do not sign this form, it will not change whether or not I can receive services from the agency listed below and any other participating agencies. However, I would need to contact each such agency directly to apply for assistance and for a determination of eligibility.

• This authorization shall remain in effect from the date of my signature below.

Today's Date: _____

Client Name (print): _____

Client Signature: _____

That I may revoke this authorization at any time by notifying the agency listed below in writing. I also understand that the written revocation must be signed and dated later than the date on this authorization. The revocations will not affect any actions taken before the receipt of the written revocation.

**KATY CHRISTIAN MINISTRIES DEPARTMENT OF SOCIAL SERVICES**
**EXPENSE REPORT**

**Applicant Name: _____**

| **CATEGORY** | **MONTHLY ACTUAL AMOUNT** |
|---|---|
| **INCOME:** | |
| Wages and Bonuses | |
| | |
| | |
| **EXPENSES:** | |
| | |
| | |
| Mortgage or Rent | |
| | |
| | |
| **UTILITIES:** | |
| Electricity | |
| Water and Sewer | |
| Natural Gas or Oil | |
| Telephone (Land Line, Cell) | |
| **FOOD:** | |
| Groceries | |
| | |
| **FAMILY OBLIGATIONS:** | |
| Child Support | |
| Alimony | |
| Day Care, Babysitting | |
| | |
| | |
| | |

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|---|---|
| | |
| **TRANSPORTATION:** | |
| Car Payments | |
| Gasoline/Oil | |
| Auto Insurance | |
| | |
| | |
| **DEBT PAYMENTS:** | |
| Credit Cards | |
| Student Loans | |
| Other Loans | |
| | |
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| **Total Expenses** | |
| | |

I certify that the information above and any other information I have provided in applying for assistance through KATY CHRISTIAN MINISTRIES Department of Social Services is true, accurate, and complete.

Applicant Signature: _____ Date: _____

Apricot Number: _____

## Authorization to Disclose Client Information to Houston Food Bank Concerning KCM Food Bank Client

In order for Katy Christian Ministries (KCM) to participate in the Houston Food Bank (HFB), HFB requires that KCM share the name and address of our clients that use our Food Pantry with HFB.

To enable you to participate in the KCM Food Pantry, you must give your consent to KCM to share your name and address with HFB. You do not have to give KCM permission to share your name and address with HFB, but if you don't, KCM will not be able to allow you to use the Food Pantry.

**I understand that I have the right to decline to share my information, but if I don't share my information, I will be unable to receive Food Pantry services. I also understand that signing this authorization form does not guarantee that I will receive Food Pantry services.**

_____
Initials

If you agree to the collecting and sharing of your name and address with HFB:

- All individuals within KCM will treat your information with respect and in a professional and confidential manner.
- Unauthorized people or organizations cannot gain access to your information without your consent.
- This authorization shall remain in effect until revoked by you in writing delivered to KCM.

I understand that I may revoke this authorization at any time by notifying KCM in writing. My revocation will not affect any actions taken before its receipt by KCM. After receipt, KCM will, as its sole responsibility, notify HFB in writing to delete your name and address from its list. From date of its receipt by KCM, I will no longer be allowed to use the Food Bank.

### AUTHORIZATION

**By signing below, I acknowledge that my name and address below is correct, and I authorize KCM to share my name and address with HFB.**

Name: _____

Address: _____

_____

_____

_____ _____

Client Signature Date

Apricot Number: _____

## Autorización para divulgar información del cliente al Banco de Alimentos de Houston con respecto al cliente del Bando de Alimentos de KCM

Para que Katy Christian Ministries (KCM) participe en el Banco de Alimentos de Houston (HFB), HFB requiere que KCM comparta el nombre y la dirección de nuestros clientes que utilizan nuestra despensa de alimentos con HFB.

Para que puedas participar en la despensa de alimentos de KCM, debes dar tu consentimiento a KCM para compartir tu nombre y dirección con HFB. No tienes que dar permiso a KCM para compartir tu nombre y dirección con HFB, pero si no lo haces, KCM no podrá permitirte usar la despensa de alimentos.

**Entiendo que tengo el derecho de rechazar compartir mi información, pero si no la comparto, no podré recibir los servicios de la despensa de alimentos. También entiendo que firmar este formulario de autorización no garantiza que recibiré servicios de la despensa de alimentos.**

_____
Iniciales

Si estás de acuerdo con la recopilación y el compartir de tu nombre y dirección con HFB:

- Todos los individuos dentro de KCM tratarán tu información con respeto y de manera profesional y confidencial.
- Las personas u organizaciones no autorizadas no podrán acceder a tu información sin tu consentimiento.
- Esta autorización permanecerá en vigor hasta que tú la revoques por escrito entregado a KCM.

Entiendo que puedo revocar esta autorización en cualquier momento notificando a KCM por escrito. Mi revocación no afectará ninguna acción tomada antes de que KCM la reciba. Después de recibirla, KCM, como su única responsabilidad, notificará por escrito a HFB para eliminar mi nombre y dirección de su lista. A partir de la fecha en que KCM reciba la revocación, ya no se me permitirá utilizar el Banco de Alimentos.

### AUTORIZACIÓN

**Al firmar abajo, reconozco que mi nombre y dirección son correctos y autorizo a KCM a compartir mi nombre y dirección con HFB.**

Nombre: _____

Dirección: _____

_____

_____

_____ _____
Firma del Cliente Fecha

Mental Health Services & Referral Questionnaire

Katy Christian Ministries partners with mental health and substance use providers to connect our clients with the support they need. If you are currently seeing a provider and want to see someone new OR if you are not seeing a provider and want to start, we can refer you. Please indicate below if you would like to be referred for support for mental health or substance use concerns.

1. I am currently seeing a mental health/ substance use counselor and **do NOT** want to be referred for additional support.
   ☐ Yes ☐ No

2. I am currently seeing a mental health/ substance use counselor and **DO** want to be referred to another mental health provider for additional support.
   ☐ Yes ☐ No

3. I am not seeing a mental health/ substance use counselor and **do NOT** want to be referred to one.
   ☐ Yes ☐ No

4. I am not seeing a mental health/ substance use counselor and **DO** want to be referred to a provider.
   ☐ Yes ☐ No

5. If you selected option 2 or 4, indicating that you want to be referred to a mental health/ substance use counselor, please select the type of insurance you have:

   ☐ Marketplace (Affordable Care Act)
   ☐ Employer-provided
   ☐ Medicaid / CHIP
   ☐ Medicare
   ☐ Other: _____

Cuestionario de servicios de salud mental y derivaciones

Katy Christian Ministries colabora con proveedores de servicios de salud mental y abuso de sustancias para conectar a nuestros clientes con el apoyo que necesitan. Si actualmente consulta con un proveedor y desea ver a alguien nuevo, o si no lo hace y desea comenzar, podemos derivarlo. Indique a continuación si desea que lo derivemos para recibir apoyo por problemas de salud mental o abuso de sustancias.

1. Actualmente estoy viendo a un consejero de salud mental/uso de sustancias y NO quiero que me deriven para recibir apoyo adicional.

   ☐ Si ☐ No

2. Actualmente estoy viendo a un consejero de salud mental/uso de sustancias y QUIERO que me deriven a otro proveedor de salud mental para recibir apoyo adicional.

   ☐ Si ☐ No

3. No estoy viendo a un consejero de salud mental/uso de sustancias y NO quiero que me deriven a uno.

   ☐ Si ☐ No

4. No estoy viendo a un consejero de salud mental o uso de sustancias y QUIERO que me deriven a un proveedor.

   ☐ Si ☐ No

5. Si seleccionó la opción 2 o 4, indicando que desea ser derivado a un consejero de salud mental/uso de sustancias, seleccione el tipo de seguro que tiene:

   ☐ Mercado (Ley de Atención Médica Asequible)
   ☐ Proporcionado por el empleador
   ☐ Medicaid / CHIP
   ☐ Medicare
   ☐ Otro: _____