

APPLICATION FOR ASSISTANCE

| | | | |
|---|------------------------------|--|---------------------------------------|
| Last 4 digits of SS # _____ | First Name _____ | Last Name _____ | Intake Worker Initials: _____ |
| | | | Intake Date: _____ |
| Client's Address: | | | Home Phone: _____ |
| Line 1: _____ | | | Work Phone: _____ |
| Line 2: _____ | | | E-mail Addr.: _____ |
| City: _____ | | Zip Code: _____ | Date of Birth: _____ |
| Marital Status: | | Race or Ethnic Background | |
| <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | | <input type="checkbox"/> White <input type="checkbox"/> Middle Eastern <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other | |
| | | | Head of Household |
| | | | <input type="checkbox"/> Female |
| | | | <input type="checkbox"/> Male |
| Client Receives: | | | |
| TANF | Section 8 | SSI Disability | Food Stamps |
| <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | \$ _____ | \$ _____ |
| | | Other Assistance | Medicaid |
| | | \$ _____ | <input type="checkbox"/> Yes |
| Employed? <input type="checkbox"/> Yes Income: \$ _____ | | | |
| Client is Requesting: | | Amount: _____ | |
| Financial Assistance <input type="checkbox"/> Yes | | Pay To: _____ | |
| Financial Mentoring <input type="checkbox"/> Yes | | Address Line 1: _____ | |
| | | Address Line 2: _____ | |
| | | City: _____ | State: _____ Zip: _____ |
| Comments: | | | |
| Referring Agency: | | | |
| <input type="checkbox"/> CSP <input type="checkbox"/> DFS <input type="checkbox"/> HS <input type="checkbox"/> NVFS <input type="checkbox"/> Other _____ | | | |
| Social Worker: | | Phone #: | E-mail Address: |

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| | | |
|---------------------------------------|----------------------------|---------------------------|
| Last 4 digits of SS # _____ | First Name _____ | Last Name _____ |
|---------------------------------------|----------------------------|---------------------------|

Number in Household:

Women: _____ Men: _____ Girls: _____ Boys: _____ Handicapped: _____ Elderly: _____

Client Family Members

| # | Family Member Name | Birth Date | Sex | Relationship | Last 4 digits of SS# |
|----|----------------------------------|------------|--|---|----------------------|
| 1 | First: Last (If different) | | <input type="checkbox"/> Female <input type="checkbox"/> Male | <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative | |
| 2 | First: Last (If different) | | <input type="checkbox"/> Female <input type="checkbox"/> Male | <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative | |
| 3 | First: Last (If different) | | <input type="checkbox"/> Female <input type="checkbox"/> Male | <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative | |
| 4 | First: Last (If different) | | <input type="checkbox"/> Female <input type="checkbox"/> Male | <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative | |
| 5 | First: Last (If different) | | <input type="checkbox"/> Female <input type="checkbox"/> Male | <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative | |
| 6 | First: Last (If different) | | <input type="checkbox"/> Female <input type="checkbox"/> Male | <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative | |
| 7 | First: Last (If different) | | <input type="checkbox"/> Female <input type="checkbox"/> Male | <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative | |
| 8 | First: Last (If different) | | <input type="checkbox"/> Female <input type="checkbox"/> Male | <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative | |
| 9 | First: Last (If different) | | <input type="checkbox"/> Female <input type="checkbox"/> Male | <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative | |
| 10 | First: Last (If different) | | <input type="checkbox"/> Female <input type="checkbox"/> Male | <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative | |