

APPLICATION FOR FOOD 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: _____ Date of Birth: _____
City: _____ Zip Code: _____

Marital Status:	Race or Ethnic Background	Head of Household
<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single	<input type="checkbox"/> White <input type="checkbox"/> Middle Eastern <input type="checkbox"/> African American	<input type="checkbox"/> Female
<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	<input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other	<input type="checkbox"/> Male

Client Receives:

TANF	Section 8	SSI Disability	Food Stamps	Other Assistance	Medicaid
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	\$ _____	\$ _____	\$ _____	<input type="checkbox"/> Yes

Employed? Yes Income: \$ _____

Client is requesting Food Delivery program: Yes

Description of Crisis (Temporary or Beyond Client's Control):

Describe how client will be self-sufficient after receiving services/intervention plan:

Is client a good candidate for ODB's financial budgeting class or mentoring program?

What other nonprofits or resources is client receiving assistance from? Has client applied for Food Stamps or other government benefits?

Is client in a stable living situation to received food delivery for the next four months?

Does client speak English or will they need a translator?

Is client in need of an emergency food delivery?

Referring Agency:

CSP DFS HS NVFS Other _____

Social Worker:

Phone #:

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