

Today's Date

Community Action Partnership

Dickinson / Williston
CLIENT INTAKE FORM

Staff Initials _____

Please check Food Pantry Weatherization Rent/Security Deposit Home Rehab Head Start
All that apply: Electric Bill Water Bill Furnace/Water Heater Heating Bill Medications
 Senior Commodities Shelter VITA Payee Other _____

PERSONAL INFORMATION / HEAD OF HOUSEHOLD				
Social Security #	First Name	MI	Last Name	Birth Date (mm/dd/yyyy)
Gender	Disabled	Race		Ethnicity
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black	<input type="checkbox"/> Multi <input type="checkbox"/> Native American <input type="checkbox"/> Other	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> NOT Hispanic or Latino
Education		Food Stamps	Health Coverage	Veteran
<input type="checkbox"/> 0-8 th Grade <input type="checkbox"/> 9 th -12 th Grad (non-grad) <input type="checkbox"/> High School Grad/GED	<input type="checkbox"/> 12+ Grade <input type="checkbox"/> Associate Deg. <input type="checkbox"/> College Degree <input type="checkbox"/> Masters Deg.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Supplement <input type="checkbox"/> Other _____ <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No

INCOME INFORMATION				
Name	Pay/Hr	Hours/Week	Pay/Month	Source/Yr
	\$		\$	
	\$		\$	
	\$		\$	
	\$		\$	

Source Codes: A = Employment B = Unemployment C = Social Security D = TANF F = SSI/SSDI G=Pension
H= General Assistance I =Other

HOUSING INFORMATION			
Address	Apt/Lot#	City	County
Zip Code	Telephone #s		
	Home:	Work:	
Household Type		Marital Status	
<input type="checkbox"/> Female Single Parent <input type="checkbox"/> Single Female Living With Partner <input type="checkbox"/> Male Single Parent <input type="checkbox"/> Single Male Living With Partner <input type="checkbox"/> Two Parent	<input type="checkbox"/> Couple <input type="checkbox"/> Single <input type="checkbox"/> Other _____	<input type="checkbox"/> Single <input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Married
Housing Status	Housing Type	Rent/House Payment	
<input type="checkbox"/> Owner <input type="checkbox"/> Renter <input type="checkbox"/> Homeless with roof <input type="checkbox"/> Homeless without roof	<input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Duplex <input type="checkbox"/> Mobile Home	\$ _____ Rental Assistance <input type="checkbox"/> Yes <input type="checkbox"/> No	

ADDITIONAL HOUSEHOLD MEMBERS

Name (Please Print)		Social Security #		Birth Date		Age	
1.							
Relation	Gender	Disabled	Ethnicity Race	Education	Food Stamps	Health Coverage	Vet
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Name (Please Print)		Social Security #		Birth Date		Age	
2.							
Relation	Gender	Disabled	Ethnicity Race	Education	Food Stamps	Health Coverage	Vet
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Name (Please Print)		Social Security #		Birth Date		Age	
3.							
Relation	Gender	Disabled	Ethnicity Race	Education	Food Stamps	Health Coverage	Vet
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Name (Please Print)		Social Security #		Birth Date		Age	
4.							
Relation	Gender	Disabled	Ethnicity Race	Education	Food Stamps	Health Coverage	Vet
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Name (Please Print)		Social Security #		Birth Date		Age	
5.							
Relation	Gender	Disabled	Ethnicity Race	Education	Food Stamps	Health Coverage	Vet
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

APPLICANT CERTIFICATION

The information provided by me to establish my eligibility is true and accurate to the best of my knowledge. I consent to the independent verification of the information by the authorized agent of the agency or its government funding source

Applicant Signature

Date