

**COMMUNITY ACTION PARTNERSHIP
CLIENT INTAKE FORM**



Today's Date

TYPE OF ASSISTANCE REQUESTED _____

| PERSONAL INFORMATION FOR HEAD OF HOUSEHOLD (List additional household members on next sheet) | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| Social Security # | First Name | MI | Last Name | Birth Date (mm/dd/yyyy) | Age | Gender | Disabled | |
| | | | | | | <input type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Race | Ethnicity | | Education | | Fuel Assistance | Food Stamps | Health Coverage | Veteran |
| <input type="checkbox"/> White <input type="checkbox"/> Multi <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Black <input type="checkbox"/> Other | <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> NOT Hispanic or Latino | | <input type="checkbox"/> 0 to 8th Grade <input type="checkbox"/> 9th - 12th Grade (non-grad) <input type="checkbox"/> High School Grad/GED <input type="checkbox"/> 12+ Grade <input type="checkbox"/> College Degree | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____ | <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other <input type="checkbox"/> None | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| INCOME INFORMATION FOR ALL HOUSEHOLD MEMBERS | | | | | |
|----------------------------------------------|--------------|----------------|---------------|-------|------------------------|
| Name | Pay Per Hour | Hours Per Week | Pay Per Month | Total | Income Source/Employer |
| | \$ | | \$ | \$ | |
| | \$ | | \$ | \$ | |
| | \$ | | \$ | \$ | |
| | \$ | | \$ | \$ | |

| HOUSING INFORMATION | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| Address | Apt/Lot# | City | County | Zip Code | Telephone # |
| | | | | | Home/Message: Work |
| Length of Stay at this address | | Years: | Months: | Days: | Just moving: |
| Household Type | | Marital Status | Housing Status | Housing Type | Rent/House Payment |
| <input type="checkbox"/> Female Single Parent <input type="checkbox"/> Male Single Parent <input type="checkbox"/> Two Parent | <input type="checkbox"/> Couple <input type="checkbox"/> Single <input type="checkbox"/> Other _____ | <input type="checkbox"/> Single <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married | <input type="checkbox"/> Owner <input type="checkbox"/> Renter <input type="checkbox"/> Homeless | <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 |

List all Members of the Household except the Head of Household. (Primary Person listed on the front of this form)

| Name (Please Print) | Social Security # | Birth Date | Age | Relation | Gender | Disabled | Race | Hispanic/ Latino | Education | Food Stamps | Health Coverage | Veteran |
|---------------------|-------------------|------------|-----|----------|--------|-------------------------------------------------------------|------|-------------------------------------------------------------|-----------|-------------------------------------------------------------|--------------------|-------------------------------------------------------------|
| 2. | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Reason for Request:

Future Plan:

Would this assistance help obtain employment or retain current employment? YES NO If yes, please explain:

Client 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.

Client Signature _____

Date _____