TWO RIVERS HEAD START AGENCY
CSBG INTAKE FORM

APPLICANT AND FAMILY INFORMATION

Last Name _____ First Name _____

Street Address _____ Apt. #_____City _____ Zip _____

Telephone_____ E-mail address (if applicable)_____

Do you or anyone in your family receive Food Stamps/SNAP? ___NO _____YES if so, how much SNAP per month?_____

No. of People in Family: _____ **Monthly Rent or Mortgage Cost $** _____

Circle below what applies to your family:

FAMILY TYPE (PRESENT TIME) **Check one:**	**HOUSING STATUS** **Check one:**	**DWELLING TYPE** **Check one:**
__SINGLE PARENT __TWO PARENT FAMILY	__RENTER If renter, do you receive Section 8/Subsidized rent? (Y/ N)	__SINGLE FAMILY HOME ___TOWNHOME/CONDO___DUPLEX __MOBILE HOME Lot #_____
__FOSTER PARENTS __TWO ADULTS NO CHILDREN __SINGLE PERSON OTHER_____	__OWNERS __HOMELESS (with roof) Explain_____ __HOMELESS (without roof) If homeless, have you stayed in a shelter in the past 90 days? (Y/N)	APARTMENT # of apartments in building __2-4 __5-10 __11 or more ___SINGLE ROOM OCCUPANCY

Do you receive any of the following services? __**LIHEAP** __**Housing Choice Voucher (Section 8)** ____**Public Housing** __**WIC** __**Childcare Co-pay Assistance**

CIRCLE TYPES OF INCOME IN THE HOME ⇨	EMPLOYMENT: Full Time	UNEMPLOYMENT BENEFITS	CHILD SUPPORT	SOCIAL SECURITY	SSI	VA BENEFITS
	Part time	WORKERS COMP	TANF	PENSION/RETIREMENT	SSDI	AABD

NAME OF PERSON WHO RECEIVES INCOME	TYPE OF INCOME	CIRCLE HOW OFTEN THEY RECEIVE INCOME	AMOUNT (Before taxes)
		Monthly Weekly Bi-Wkly 2 Times a month	
		Monthly Weekly Bi-Wkly 2 Times a month	
		Monthly Weekly Bi-Wkly 2 Times a month	
		Monthly Weekly Bi-Wkly 2 Times a month	

If unemployed, how long/why?_____If no income, how do you support yourself and/or family?_____

FAMILY INFORMATION (Please fill in completely)

Names of all Household Members	Date of Birth	Age	Military Service: No If Yes, Vet or Active	Disabled Yes No Unknown	Gender Male Female Other	Social Security Numbers	Health Insurance Medicaid Medicare Employment based CHIP Direct purchase VA Health care	Race Black Hispanic White Asian Native Am. Other	Highest Level of Education so far Pre-k 0-8 9-12(non- grad) HS Diploma/GED 2 or 4yr degree	Relationship to Applicant Spouse Son Daughter Grandchild ETC
										SELF

*IF THERE ARE YOUTH AGES 14-18 IN THE HOME, ARE THEY IN SCHOOL?____YES/ NO_____ ARE YOUTHS WORKING?____YES/NO_____

APPLICATION AFFIRMATION AND AUTHORIZATION TO VERIFY INFORMATION

APPLICANT'S STATEMENT: I certify that the above information is an accurate and complete disclosure of the requested information. I hereby acknowledge that the information relating to determination of my eligibility requires verification and/or documentation, and by my signature, I authorize others to release such information as may be required for determination of my eligibility.

Signature of Applicant _____Date: _____ Intake Staff Signature _____Date:_____

OFFICE USE ONLY **Stars ID:**_____ **Total HH 90 Day Income $**_____

MONETARY ASSISTANCE:

A. Voucher #_____Amount Approved $ _____ Date _____Authorized By_____

B. Date Check Issued _____ Check # _____ Vendor Name & Address:_____

C. Staff entering approval in STARS: _____