



### INTAKE APPLICATION

Service(s) you are applying for:

Date: \_\_\_\_\_

HEATING/UTILITY ASSISTANCE <input type="checkbox"/>	HOME WEATHERIZATION <input type="checkbox"/>	HOUSING SERVICES <input type="checkbox"/>	VETERANS SERVICES <input type="checkbox"/>	HEAD START <input type="checkbox"/>	EARLY HEAD START <input type="checkbox"/>	MEALS ON WHEELS <input type="checkbox"/>	CONGREGATE MEALS <input type="checkbox"/>	COMMODITY FOODS <input type="checkbox"/>
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### Household Information

FIRST NAME	LAST NAME	SSN	DOB	SEX (M or F)	RACE	HISPANIC (Y or N)	DISABLED (Y or N)	VETERAN (Y or N)	EDUCATION LEVEL	TYPE OF HEALTH INSURANCE	RELATIONSHIP TO HoH
<u>Head of Household</u>		- -	/ /								Self
		- -	/ /								
		- -	/ /								
		- -	/ /								
		- -	/ /								
		- -	/ /								
		- -	/ /								

Mailing Address (city/state/zip/county): \_\_\_\_\_

Physical Address (if different): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell/Other Phone: \_\_\_\_\_

## General Information

**Marital Status:**

MARRIED <input type="checkbox"/>	SINGLE <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	SEPARATED <input type="checkbox"/>	PARTNER <input type="checkbox"/>	WIDOWED <input type="checkbox"/>
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**Family Type:**

MARRIED <i>(Living w/children)</i> <input type="checkbox"/>	MARRIED <i>(No children)</i> <input type="checkbox"/>	MARRIED <i>(Spouse in nursing home)</i> <input type="checkbox"/>	MULTIPLE ADULTS <i>(Living w/children)</i> <input type="checkbox"/>	MULTIPLE ADULTS <i>(No children)</i> <input type="checkbox"/>	FOSTER PARENT <input type="checkbox"/>	GRAND- PARENT <input type="checkbox"/>	SINGLE <i>(Living w/children)</i> <input type="checkbox"/>	SINGLE <i>(Living alone)</i> <input type="checkbox"/>
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Do you receive food stamps? \_\_\_\_\_ If yes, amount? \_\_\_\_\_ Do you receive WIC benefits? \_\_\_\_\_

**Do you have Childcare:**

YES - Private <input type="checkbox"/>	YES - Subsidized <input type="checkbox"/>	NO <input type="checkbox"/>
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**Do you have Health Insurance:**

MEDICAID <input type="checkbox"/>	MEDICARE <input type="checkbox"/>	PRIVATE <input type="checkbox"/>	NONE <input type="checkbox"/>
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**Medication:**

NEEDS MET <input type="checkbox"/>	COULD USE ASSISTANCE <input type="checkbox"/>
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**Do you have Transportation:**

YES <input type="checkbox"/>	NO <input type="checkbox"/>
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**Special needs children:**

YES <input type="checkbox"/>	NO <input type="checkbox"/>
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Have you received services from our agency before? \_\_\_\_\_ If yes, when? \_\_\_\_\_

Have you received services from another agency? \_\_\_\_\_ If yes, when & what agency? \_\_\_\_\_

## Income Information

*Please use one line for each type of income.*

RECIPIENT NAME	SOURCE <small>(Wages, Social Security, SSI, Child Support, Scholarships/Grants, Unemployment, etc.)</small>	EMPLOYMENT STATUS <small>(Full time, Part time, Not employed)</small>	MONTHLY GROSS AMOUNT
<b>TOTAL HOUSEHOLD MONTHLY INCOME:</b>			

## Dwelling Information

<b>Home Ownership:</b>	OWN <input type="checkbox"/>	RENT- Unsubsidized <input type="checkbox"/>	RENT - Subsidized <input type="checkbox"/>	LIVING W/FRIENDS OR FAMILY <input type="checkbox"/>	HOMELESS <input type="checkbox"/>	TRANSITIONAL/SHELTER <input type="checkbox"/>	
<b>Home Type:</b>	SINGLE FAMILY <input type="checkbox"/>	MOBILE <input type="checkbox"/>	MULTI (2+ units) OR DUPLEX <input type="checkbox"/>		APARTMENT COMPLEX <input type="checkbox"/>		
<b>Structure:</b>	WOOD FRAME <input type="checkbox"/>	BRICK <input type="checkbox"/>	MASONRY <input type="checkbox"/>	MOBILE HOME <input type="checkbox"/>	MULTI-UNIT <input type="checkbox"/>		
<b># of Stories:</b> _____	<b>Location:</b>		CITY LIMITS <input type="checkbox"/>	RURAL <input type="checkbox"/>	<b>Monthly rent/mortgage:</b> _____		
<b>Heating Fuel Type:</b>	NATURAL GAS <input type="checkbox"/>	PROPANE <input type="checkbox"/>	ELECTRIC <input type="checkbox"/>	FUEL OIL <input type="checkbox"/>	WOOD <input type="checkbox"/>	WOOD PELLETS <input type="checkbox"/>	<b>Electric Provider:</b> _____

## Certification Statement

*I certify that the information I have provided is complete and correct to the best of my knowledge and is made in good faith. I further give my consent to Community Action Alger-Marquette personnel to verify eligibility and provision of services. I am aware that this application may be forwarded to other departments of Community Action Alger-Marquette. I understand that this information will be used to determine eligibility for any and all services provided to me by Community Action Alger-Marquette. I further understand that this information may be disclosed to other service providers in order to determine my eligibility for their services. This information will be shared on a need-to-know basis only.*

**Applicant Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**CAAM Staff Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_