

**Community Action Wayne/Medina
CSBG Intake Form**

Applicant Name _____ SS# _____

Address _____ Apt. # _____ County _____

City _____ Zip Code _____ Telephone (____) _____ DOB ____/____/____

Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Other _____	Health Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Self-Insured <input type="checkbox"/> Private <input type="checkbox"/> Uninsured <input type="checkbox"/> Other _____
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Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No	Education <input type="checkbox"/> 0-8 <input type="checkbox"/> 9-12(Non-Grad) <input type="checkbox"/> HS Grad/GED <input type="checkbox"/> 12+ <input type="checkbox"/> College Grad <input type="checkbox"/> Unknown	Family Type <input type="checkbox"/> Single Parent/Male <input type="checkbox"/> Single Parent/ Female <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Two Parent <input type="checkbox"/> Other
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Food Stamps <input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$ _____	Cash Assistance <input type="checkbox"/> Yes <input type="checkbox"/> No Case Number _____	Housing <input type="checkbox"/> Own <input type="checkbox"/> Rent Amount \$ _____	Rental Assistance <input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$ _____	Landlord Information Name _____ Address _____ Phone Number (____) _____
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Number In Household _____	Client Income <input type="checkbox"/> Weekly <input type="checkbox"/> Annual <input type="checkbox"/> Bi-weekly <input type="checkbox"/> 13 Weeks <input type="checkbox"/> Monthly	Sources of Income <input type="checkbox"/> Employment <input type="checkbox"/> Unemployment <input type="checkbox"/> Social Security <input type="checkbox"/> Pension <input type="checkbox"/> TANF <input type="checkbox"/> SSI/SSDI <input type="checkbox"/> DA <input type="checkbox"/> Other _____ Amount \$ _____
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Other Household Members

SS #					
Last Name					
First Name					
Date of Birth					
Gender					
Disabled					
Ethnicity					
Education					
Health Insurance					
Veteran					

Other Household Income

Household Member _____	Client Income <input type="checkbox"/> Weekly <input type="checkbox"/> Annual <input type="checkbox"/> Bi-weekly <input type="checkbox"/> 13 Weeks <input type="checkbox"/> Monthly	Sources of Income <input type="checkbox"/> Employment <input type="checkbox"/> Unemployment <input type="checkbox"/> Social Security <input type="checkbox"/> Pension <input type="checkbox"/> TANF <input type="checkbox"/> SSI/SSDI <input type="checkbox"/> DA <input type="checkbox"/> Other _____ Amount \$ _____
Household Member _____	Client Income <input type="checkbox"/> Weekly <input type="checkbox"/> Annual <input type="checkbox"/> Bi-weekly <input type="checkbox"/> 13 Weeks <input type="checkbox"/> Monthly	Sources of Income <input type="checkbox"/> Employment <input type="checkbox"/> Unemployment <input type="checkbox"/> Social Security <input type="checkbox"/> Pension <input type="checkbox"/> TANF <input type="checkbox"/> SSI/SSDI <input type="checkbox"/> DA <input type="checkbox"/> Other _____ Amount \$ _____

(Use additional form if more income needs to recorded.)

Total Monthly Income \$ _____	Total 90 day income \$ _____
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I CERTIFY THAT THIS STATEMENT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, AND AUTHORIZE THE RELEASE OF ANY OR ALL INFORMATION NECESSARY FOR VERIFICATION PURPOSES

Client Signature _____ Date _____
Staff Signature _____ Date _____