**Basic Intake Form**

Welcome! Please tell us a bit about yourself so we can offer services that best meet your needs. We ask for demographic information to meet requirements from our funders. All your personal information is confidential. Please see the attached FAQs for more information and guidance on filling out this form.

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|  **Contact & Demographic Information:** |
| **Last Name:** |            |  **First Name:** |            |  **M.I.** |            |
| **Date of Birth:** |            |  **Age:** |            |
| **Gender:** [ ]  Male [ ]  Female [ ]  Other gender not listed:  |  |
| **Home Address** Line 1: |            |
| Line 2 (Apt/Unit/Floor #): |            | City: |            |
| Zip: |            |  County: |            |  State: |            |
| **Mailing Address** Line 1: |            |
| Line 2 (Apt/Unit/Floor #): |            | City: |            |
| Zip: |            |  County: |            |  State: |            |

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| **Location Comments** (additional directions for home or mailing address): |
|       |

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| --- | --- | --- | --- |
| **Home Phone:** |            | **Cell Phone:** |            |
| **Email:** |            |

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| **Primary language:** [ ]  English [ ]  Spanish [ ]  Other: |       |
| **Ethnicity:** [ ]  Hispanic or Latino [ ]  Not Hispanic or Latino  |
| **Race, select all that apply:** |
| [ ]  American Indian/Alaska Native | [ ]  Native Hawaiian or Pacific Islander |
| [ ]  Asian or Asian American | [ ]  White |
| [ ]  Black or African American | [ ]  Other not listed:  |       |
| **Do you live:** [ ]  Alone [ ]  With Others |
| **Number of people in your household** (including you):  |       |

**Is your income above or below the amount listed for your household size:**

[ ]  Above [ ]  At/Below

|  |  |  |
| --- | --- | --- |
| Household Size | Monthly Income | Annual Income |
| 1 | $1,073 | $12,880 |
| 2 | $1,452 | $17,420 |
| 3 | $1,830 | $21,960 |
| 4 | $2,208 | $26,500 |
| For each additional person, add $4,540 to annual income |

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|  **Emergency Contact:** |

**Primary Emergency Contact:**

|  |  |
| --- | --- |
| Name: |            |
| Phone: |            |  Relationship:  |            |

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|  **Interest in Other Services:** |

**Health Insurance** (select all that apply):[ ]  Medicaid [ ]  Medicare [ ]  Other [ ]  None

**Are you interested in learning about nutrition and a healthy diet?** [ ]  Yes [ ]  No

**Would you like to hear about other services?** [ ] Yes [ ]  No

**If yes, how can we contact you?** [ ]  Email [ ]  Mail [ ]  Phone

|  |  |
| --- | --- |
| **What services are you interested in?** |       |
|       |

**Disclosures and Waivers**

*I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service provider and I herewith give my consent to do so.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:**  |            |  **Date:** |            |

***For Office Use Only –***

*(If filled out by assessor or via phone, please have assessor check here and sign below* [ ] )

|  |  |  |  |
| --- | --- | --- | --- |
| **Filled Out By:**  |            |  **Date:** |            |