

CSBG Customer Intake Application

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|---|---|--|--|--|
| Client Number: | Program Name: | | | Application Date: |
| | <input type="checkbox"/> Emergency Services <input type="checkbox"/> STEP <input type="checkbox"/> GAPS | | | |
| Primary Applicant | | | | |
| First Name: | M.I.: | Last Name: | | |
| | | | | |
| Social Security Number: | Date of Birth: | Gender: | | |
| | | <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other | | |
| Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No | Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No | Food Stamps: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Current Residential Address: | | | | |
| Current Mailing Address (if different from above): | | | | |
| City: | State: | Zip Code: | County: | |
| Phone Number: | | Email Address: | | |
| Race: | | Education: | | Ethnicity: |
| <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown/not reported <input type="checkbox"/> Other | | <input type="checkbox"/> 0-8 <input type="checkbox"/> 9-12 (Non Grad) <input type="checkbox"/> HS Grad/GED <input type="checkbox"/> 12 + Post-Secondary <input type="checkbox"/> 2-4 Yr. Grad College | | <input type="checkbox"/> Hispanic, Latino or Spanish Origins <input type="checkbox"/> Not Hispanic, Latino or Spanish Origins |
| Household Information: | | | | |
| # In Household: | Family Type | Building Type | Work Status | Health Insurance Type |
| | <input type="checkbox"/> Single Parent/Female <input type="checkbox"/> Single Parent/Male <input type="checkbox"/> Two-Parent Household <input type="checkbox"/> Single Person <input type="checkbox"/> Two Adults/No Children <input type="checkbox"/> Non-related Adults with children <input type="checkbox"/> Multigenerational Household <input type="checkbox"/> Other | <input type="checkbox"/> Mobile Home <input type="checkbox"/> Single Family <input type="checkbox"/> Multi-family low- rise (3 stories or less) <input type="checkbox"/> Multi-family high-rise (3 stories or more) | <input type="checkbox"/> Employed full-time <input type="checkbox"/> Employed part-time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Unemployed (short-term, 6 months or less) <input type="checkbox"/> Unemployed (long-term, more than 6 months) <input type="checkbox"/> Unemployed (not in labor force) <input type="checkbox"/> Retired <input type="checkbox"/> Unknown/not reported <input type="checkbox"/> Youth ages 14-24 who are neither working nor in school | <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private/Employment <input type="checkbox"/> Self-Insured/Direct Pay <input type="checkbox"/> None <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults |
| Housing Status | | | | |
| <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Other Permanent <input type="checkbox"/> Housing <input type="checkbox"/> Homeless <input type="checkbox"/> Other | | | | |
| Source of Income: | | | Income Period: | Income Amount: |
| <input type="checkbox"/> Employment <input type="checkbox"/> Unemployment <input type="checkbox"/> Self-Employment <input type="checkbox"/> No Income <input type="checkbox"/> Social Security <input type="checkbox"/> TANF/ADC <input type="checkbox"/> SSI/SSD <input type="checkbox"/> Pension <input type="checkbox"/> Disability <input type="checkbox"/> Child Support <input type="checkbox"/> Other (Please Specify) _____ | | | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly | |
| Household Members: | | | | |
| Last Name: | | | | |
| First Name: | | | | |
| Social Security # | | | | |
| Date of Birth: | | | | |
| Gender: | | | | |
| Race: | | | | |
| Education: | | | | |
| Ethnicity: | | | | |
| Disabled Y/N: | | | | |
| Health Insurance: | | | | |
| Relationship (i.e. daughter, son, spouse etc.) | | | | |
| Income source: | | | | |

I certify that this statement is true and correct to the best of my knowledge, and I authorize the release of any or all information necessary for verification purposes.

Applicant Signature: _____ Date: _____