Agency:
Date of Intake:
Check if Certified as U.S. Citizen

Applicant Information & Address				Location Zones			Monthly Fixed Expenses	
Applicant Name		Referred By		County			Shelter	
SSN		Family Type		District No.			Utility	
Home Phone	Cell:	Housing Status		Census Tract No.			Insurance	
Work Phone		Housing Type		Township			Medical	
Home Address		Primary Fuel		Village			Childcare	
		Language		Community Group			Food	
Mailing Address		Transportation		Other Zone			Transportion	
		Non US Family	☐	City Limits	☐		Other	

Name of Household Member / Social Security #	DOB	Race	Sex	Education	Marital Status	Veteran	Food Stamps	Reg. Voter	Disp. Homemaker	Handicap	Disability	Health Insurance	Medicare Ins.	Medicaid Ins.
						☐	☐	☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐	☐	☐
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						☐	☐	☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐	☐	☐

Household Size	Method of Information Verification			30 Day Income	Assets	Avg. Monthly Expenses	Avg. Annual Expenses	Avg. Monthly Income	FPL%	* Annual Income
	Self-Dec ☐	Income Docs ☐	Phone Verify ☐							

SELF DECLARATION OF NEED

I declare that to the best of my knowledge I am the only member of the household represented in the application that has applied for assistance in the program. I certify that my household meets the income guidelines of this program, and that all information concerning my income and the number of people living in my home has been disclosed during the interview. I authorize _____ to share and obtain relevant information with community partners concerning my application in order to secure additional assistance for my household. Further, I certify that all information that has been spoken or presented to _____ in order to receive assistance of any type is true and correctly represented on this application, realizing that misrepresentation is illegal. I understand that any violation of the above mentioned items will result in denial/termination of assistance and may result in fines or imprisonment. I have been informed that I have a right to a Fair Hearing if I feel I have not been fairly treated in the determination of my eligibility for services. Further, I understand that a Fair Hearing may be requested in writing within 10 days to _____.
In accordance with Federal Law, _____ is prohibited from discrimination on the basis of race, color, national origin, sex, age or disability.

Applicant Signature: _____
Date: _____

Agency Representative Signature: _____
Date: _____