

**COMMUNITY ACTION COUNCIL OF HOWARD COUNTY
APPLICATION FOR ASSISTANCE**

CUSTOMER INFORMATION

Family Type:	Single Parent Female, Single Parent Male, Two-Parent, Single Person, Two Adults (No Children), Foster Parent, Guardian		
Last Name:	First:	Middle:	Suffix:
Social Security Number:	Date of Birth:		
Primary Phone Number:	Other Phone Number:		

HOUSEHOLD INFORMATION

Address:	Apt Number:	Monthly Cost:
City:	State:	Zip Code:
Type of Home:	Apartment/Multifamily, Mobile Home, 1-Story Single Family, 2- or 3- Story Single Family, Single Family Row or Town House	
If Homeless – Prior Residence Type:	How Long There?	

DEMOGRAPHIC INFORMATION

Name	Social Security Number	Date of Birth	Gender (M/F)	Ethnicity (Hispanic?)	Race	Marital Status	Educational Level	US Citizen (Y/N)	Disability (Y/N)	Language spoken in the home other than English
Last First					Black White Asian Pacific Islander Native American/Alaskan Bi-Racial	N/A (Child) Divorced Married Never Married Separated Widowed Unknown				

ASSISTANCE INFORMATION

Last Name	First Name	Food Stamps	Medical Assistance	MCHIP	WIC	TCA	TANF Child Care	TANF Transportation	VA Medical Services	Medicare	Housing Subsidy	Military Family	Veteran

INCOME INFORMATION

Name	Employment Status	Hours worked last week	Employer	Income from Employment	Pay Interval	Additional Income Sources	Amount of Income	Interval
	Full Time, Part Time, Unemployed, Training or School, Disabled or Retired				Weekly Bi-Weekly Monthly	Child Support, TCA, SSI, etc.		Weekly Bi-Weekly Monthly

APPLICANT CERTIFICATION

I certify that the information I have provided is true and correct. I understand that misinformation or refusal to disclose information which is essential for a determination of eligibility is a basis for disapproval of my application. Also, I hereby authorize Community Action Council of Howard County to verify/obtain any information and documentation which will assist in determining my eligibility for assistance.

APPLICANT SIGNATURE:	DATE:
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PROGRAM APPLICATION INFORMATION – Please check the program(s) for which you are making application.

Housing _____ Energy _____ Food Bank _____ Other _____

For Office Use Only:

DATA ENTRY

	Date Entered:	Entered By:	Community Worker Name:
Intake			
Registration			
Case Management			
Eligibility			
Certification			
Enrollment			
Service Units			

CERTIFICATION OF ELIGIBILITY

Supervisor Name (Printed):	
Signature:	Date:

For Food Bank use only:

REFERRAL

Date:	Agency:	Worker:
Date of Previous Referral:	Eligible (Y/N):	Signature:

SERVICE

Community Worker:	Date Service Provided:	Amount of Food _____ lbs.
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