



BUILDING BLOCKS OF NJ

Housing Assistance Program

All questions contained in this questionnaire are strictly confidential.

Original Date:
Dates Revised:

Name: <i>(Last, First)</i>	Household ID# <small>(Office Use Only)</small>
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
New Client: <input type="checkbox"/> YES <input type="checkbox"/> NO Existing Client: <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of last food package received:

PERSONAL HEALTH HISTORY

Type of ID:	<input type="checkbox"/> State ID <input type="checkbox"/> Driver's License	Explain if other:
	<input type="checkbox"/> Passport <input type="checkbox"/> Student ID	Address:
	<input type="checkbox"/> Birth Cert <input type="checkbox"/> Employee ID <input type="checkbox"/> Other	City and Zip: Phone:

Are you homeless? YES NO
 Are you disabled? YES NO

Household Information (please answer all questions)

1	Total # of children under the age 18 in your household	
2	Total # of adults ages 18 to 55 in your household	
3	Total # of seniors over the age 55 in your household	
4	Total # of individuals living in your household	
I certify all statements are true and accurate to the best of my knowledge, and that the members in my household will benefit from services provided by The Building blocks of NJ Applicant Signature: _____ Date: _____		

Employment Status (Please check all that apply)

<input type="checkbox"/>	Employed	
<input type="checkbox"/>	Unemployed	
<input type="checkbox"/>	Retired	
<input type="checkbox"/>	Disabled	
<input type="checkbox"/>	Student	
<input type="checkbox"/>	Other	Explain:

Please turn to next page

YOUR HOUSEHOLD:

Which best describes your household? (Please check one)	<input type="checkbox"/> Single Parent (female)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Single Parent (male)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> 2 parent family	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> 2+ adults w/children	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Single adult(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Married (no children)		

PLEASE CHECK ALL PUBLIC BENEFIT PROGRAMS YOU ARE CURRENTLY PARTICIPATING IN:

SNAP (former food stamp program)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
LIEAP (energy assistance)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Section 8 (housing assistance)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
CHIP (children's Health Insurance)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Social Security	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unemployment Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medicaid/ Medicare	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Senior Commodities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
School Meals (free and reduced priced lunches)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Provide any information you may see needed:

Signature of Client:

Date:

Signature of Coordinator:

Date: