Orcas Community Resource Center - Client Intake

Date:		**Staff Initials:**
Client Name:	**Preferred Name:**	
Cell Phone:	**Other Phone:**	
Physical Address:	**Mailing Address:**	
Email:		
Emergency Contact Name & Number:		
Preferred Method of Contact phone ☐ email ☐ text ☐		
Date of Birth:	**Age:**	**Gender:**
Race:	**Ethnicity:**	**Preferred Pronoun:**
Primary Language:		**Veteran?** no
Highest Level of Education:		**Disabled?** no

Whom may we thank for the referral?

What brings you to the Resource Center today?

Have you sought out assistance previously from OCRC or any other local agencies?

- ☐ **Food Bank**
- ☐ **Senior Center**
- ☐ **DSHS**
- ☐ **Community Wellness Program (CWP)**
- ☐ **Dental Van**
- ☐ **Safe San Juans**
- ☐ **Rental Assistance**
- ☐ **TVP (transportation voucher program)**
- ☐ **Lions Club**
- ☐ **Veterans Assistance**
- ☐ **OPALCO (ProjectPal)**
- ☐ **OPALCO (Energy Assist Program)**
- ☐ **Emergency Assistance**
- ☐ **Other**

Current Housing: ☐ **Own** ☐ **Rent** ☐ **Homeless** ☐ **Temporary** ☐ **Roomer/Boarder**

If other, please explain:

Monthly Mortgage Payment/Rent: $

How do you heat your home? ☐ **Electric** ☐ **Propane** ☐ **Wood**

Health Insurance: ☐ **Medicaid** ☐ **Medicare** ☐ **Uninsured** ☐ **Other Insurance**

If other insurance, please list insurance carrier:

Employment Status: ☐ **Full Time** ☐ **Part Time** ☐ **Unemployed** ☐ **Retired** ☐ **Disability**

If employed, please list employer:

HOUSEHOLD MEMBERS	**# Adults**		**# Children**		**# Total** 2
Name	Gender	Relationship	DOB	Insured no	Disabled no
Name	Gender	Relationship	DOB	Insured	Disabled
Name	Gender	Relationship	DOB	Insured	Disabled
Name	Gender	Relationship	DOB	Insured	Disabled
Name	Gender	Relationship	DOB	Insured	Disabled
Name	Gender	Relationship	DOB	Insured	Disabled

GROSS MONTHLY INCOME (list all household members' earnings)		**HOUSEHOLD TOTAL**
Name	Source of Income & Amount 0	Total 0
Name	Source of Income & Amount	Total
Name	Source of Income & Amount	Total
Name	Source of Income & Amount	Total
Name	Source of Income & Amount	Total
Name	Source of Income & Amount	Total
Name	Source of Income & Amount	Total

SUPPORT NETWORK (extended family, friend, pastor, sponsor, etc.)		
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

My signature below indicates that all of the information on this form is both true and accurate. OCRC may use this information to determine elibility for programs and benefits as well as provide data to determine local, county, and state program needs. OCRC may transfer the information contained within this document to their private database. OCRC will not use the information contained in this application for any other reason without my written consent.

_____ _____

Client Signature **date**

OCRC Staff Notes: