MIL SCREENING FORM

email this form to kim.pate@maximumimpactlove.org

Date: _____

Referral Taken By: _____

Full Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____

Phone Number: _____ **Employer:** _____

Spouse/Partner: _____ **Phone Number:** _____

Children: _____ **Age:** _____ **Children:** _____ **Age:** _____

Children: _____ **Age:** _____ **Children:** _____ **Age:** _____

Children: _____ **Age:** _____ **Children:** _____ **Age:** _____

School(s) Attending: _____

Referred By: _____

Phone Number: _____ _____

Current Living Situation: _____

Employed: Yes / No **Employer:** _____ **Phone Number:** _____

Evictions: Yes / No **When:** _____

TANF: _____ **Food Stamps (EBT): $**_____ **Child Support: $**_____ **SSI / SS: $**_____

Alcohol/Drug Use: Yes / No **Prayer Needed:** Yes / No

Attend Church: _____

Resources Contacted: _____

_____

Rental Request (Amount): $_____

Utility Request (Amount): $_____

Intake Signature: _____ **Date:** _____