



Macomb Diaper Bank Intake Form

Please Print Clearly

Name of Client _____

Email Address _____

Phone # _____

Child First Name or If Pregnancy may use Unknown _____

Child's Age or Due Date _____

Services received in the Last 12 months (i.e., WIC, Medicaid) _____

Both forms must be completed and returned by the first Friday of each month to receive services. Forms may be emailed to (admin@bettyeharrisfoundation.net)

You must be eight months pregnant to start receiving diapers. **(Effective Immediately)**

The agency picks up diapers on the second **Tuesday or Wednesday** of each month.

Diapers must be picked up within **48 hours** of the agency pickup date, or they will go to the next client. (It is your responsibility to contact the agency for pick-up information).

The form can be downloaded from (www.bettyeharrisfoundation.net).

We Do Not Deliver

Signature _____ Date _____

18121 E. 8 Mile Rd Suite 105 Eastpointe, MI 48021 ~ www.bettyeharrisfoundation.net ~ 586-541-8357

**2023 DIAPER BANK PROGRAM
FAMILY INFORMATION FORM**

Community Partner/Agency: Metropolitan Detroit Diaper Bank

Name of Applicant: _____

County of Residence: _____

INFORMATION FOR CHILDREN 36 Months & Younger				For Office Use Only SUPPLIES RECEIVED		
Childs First Name	Date of Birth	Current Age	Diaper Size	Diapers	Wipes	Ointment

CERTIFICATION (REQUIRED)

I declare under penalties of perjury that the foregoing representations of the income for my household are true, correct, accurate, and complete in all respects. I understand that providing false, incomplete, or inaccurate information on application forms may result in termination of participation in the program and possible criminal liability.

Applicant Signature _____ Date _____

Please indicate below which program applies to your household (check all that apply):

Current recipient (within past 12 months) of any of the following:

- Food Assistance Program/Supplemental Nutrition Assistance Program (SNAP)
- Family Independence Program
- State Emergency Relief
- Weatherization
- Community Services Block Grant Assistance
- Low- Income Household Assistance Program (LIHAP)
- Supplemental Security Income (SSI)

At or below 200% Federal Poverty Level (FPL)

Current enrollment in other program not listed above with an income eligibility requirement at/below 200% of FPL – Program Name: _____

Completed forms must be submitted monthly to the lead Community Action Agency administering the funding.

