UNITED BOARD OF MISSIONS

CLIENT INFORMATION

Have you received assistance from Community Care Prayer Outreach? Y / N

Date: ___________ Volunteer: __________________ Homeless? Y or N Client ID# ___________

Who referred you to the Mission? ______________________________ Veteran or Active Duty Y or N

Client Name: (Last, First) ____________________________________ Telephone ___________________

Age: ____ DOB: _________ Gender: ____ Race: ____ Hisp: Y or N Education Completed: ____________

Address: _____________________________________City__________________Zip________________

Client email: ____

Spouse's Name: (Last, First) ___________________________________ Telephone__________________

Age: ____ DOB: _________ Gender: ____ Race: ____ Hisp: Y or N Education Completed: ____________

Marital Status: ______________________ ***(Verify if residential address is also the mailing address)***

Does Client have health insurance? Y or N Does Spouse have health insurance? Y or N

Do you have a Church affiliation? ____

HOUSEHOLD INFORMATION

(List information on ALL other people living in the household)

Name: ___________________Relationship: ________DOB: __/__/____ Age: ___Doc: Y or N Ins: Y or N
Race: ____ Hisp: Y or N Grade: ____ or if over 18 Educ. Completed? ____________________

Name: ___________________Relationship: ________DOB: __/__/____ Age: ___Doc: Y or N Ins: Y or N
Race: ____ Hisp: Y or N Grade: ____ or if over 18 Educ. Completed? ____________________

Name: ___________________Relationship: ________DOB: __/__/____ Age: ___Doc: Y or N Ins: Y or N
Race: ____ Hisp: Y or N Grade: ____ or if over 18 Educ. Completed? ____________________

Name: ___________________Relationship: ________DOB: __/__/____ Age: ___Doc: Y or N Ins: Y or N
Race: ____ Hisp: Y or N Grade: ____ or if over 18 Educ. Completed? ____________________

Name: ___________________Relationship: ________DOB: __/__/____ Age: ___Doc: Y or N Ins: Y or N
Race: ____ Hisp: Y or N Grade: ____ or if over 18 Educ. Completed? ____________________

Name: ___________________Relationship: ________DOB: __/__/____ Age: ___Doc: Y or N Ins: Y or N
Race: ____ Hisp: Y or N Grade: ____ or if over 18 Educ. Completed? ____________________

Name: ___________________Relationship: ________DOB: __/__/____ Age: ___Doc: Y or N Ins: Y or N
Race: ____ Hisp: Y or N Grade: ____ or if over 18 Educ. Completed? ____________________

By signing this form, I affirm that all my answers have been true and correct to the best of my knowledge. My signature constitutes consent for the United Board of Missions and its agents to contact any source to verify information necessary for eligibility. I will cooperate fully with UBM personnel to obtain information from any source to verify statements I have made.
I understand my application will be considered without regard to race, color, religion, creed, national origin, sex, or political belief and that I may request a review of the decision made on my application.
YOU MUST RETURN ANY REQUIRED INFORMATION WITHIN 3 BUSINESS DAYS.

Client Signature: ____DATE: ________________

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UBM INTERVIEW DATA

MONTHLY INCOME:

Last 30 days (Gross)

Employment _____
Social Security _____
Pension _____
Unemp. Comp. _____
TANF _____
SSI _____
TOTAL: _____

SUPPORT:

Child Support _____
Food Stamps _____
Rent Asst. _____
Utility Asst. _____

MONTHLY EXPENSES:

Rent/Mortg. _____
Entergy _____
Gas _____
Water _____
Phone _____
Rentals _____
Cable/Internet _____
Household Exp. _____
Food _____
Medical Exp. _____

Life Ins. _____
Hosp. Ins. _____
Home Ins. _____
Car Ins. _____
Gasoline _____
Auto Loan _____
Credit Cards _____
Other Loans _____
Miscellaneous _____
Miscellaneous _____
TOTAL: _____

SERVICE REQUESTED: Food _____ Clothing _____ Rent _____ Utilities _____ Medical _____
Other _____

Explain client's situation: *(What has caused the emergency?)*

_____
_____
_____
_____
_____
_____
_____
_____
_____

If loss of job, are you signed up with Texas Workforce? Y or N _____

Does Client need to bring in additional Information or Documentation? **Y or N**

_____
_____

Has Client received assistance from any other organizations? Y / N (If YES please list below)

_____

Was the client referred to additional places or agencies by UBM? **Y or N**

_____
_____
_____

SERVICES GRANTED: Food _____ Clothing _____ Rent _____ Utility _____ Medication _____
Transportation _____ Other _____

PLEDGE WAS MADE: Y or N Amount $_____ To: _____

This facility is an equal opportunity provider.

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