SPRINGFIELD FAMILY CENTER APPLICATION

DATE OF COMPLETE PAPERWORK:				
LAST NAME:		**FIRST NAME:**		
ADDRESS:				
TOWN:		**STATE:**		
NUMBER OF HOUSEHOLD:		**PHOTO ID: Y/N**	**ID#:**	**STATE:**
NO MORE THAN 2 ADULTS PER HOUSEHOLD		**PROOF OF RESIDENCY: Y/N**		
ADULTS:	**CHILDREN:**	**STAFF INITIALS:**		

DATES OF FOOD SHELF ACCESSED:

SPRINGFIELD FAMILY CENTER SERVICES INTAKE

Form must be filled out COMPLETELY

Head of Household:_____ **Date of Birth**:_____

Street Address:_____ **Town**:_____ **State**:_____

Mailing Address:_____ **Town**:_____ **State**:_____

Length of Time at Address:_____ **Phone Number**:_____

CIRCLE ONE:

Gender: M/F **Veteran**: Y/N **Marital Status**: Single Married Separated Divorced

Race: White Black Hispanic American Indian Asian Pacific Islander Alaskan

Are you employed: Y/N **Employment Type**: Full Time/ Part Time **Disabled**: Y/N

Receiving State Assistance Benefits? Y/N **Receiving Social Security Benefits**: Y/N

Education Level: K-8____ 9-12(non-grad) ____ High School Grad/GED____ Some College____
College Grad____ Other____

Transportation:

Do you have transportation? Y/N **Personal Vehicle**? Y/N **Bus**? Y/N **Other**? _____

Housing Information:

Do you have your own housing? Y/N **Do you rent**? Y/N **Do you live with someone else**? Y/N **Homeless**? Y/N

Cost per Month: ***Mortgage***: $_____ ***Rent***: $_____ ***Lights***: $_____ ***Heat***: $_____ ***Phone***: $_____

What is included in your housing? (*Please circle one*): Lights Heat Phone Cable Trash Snow-Removal Food

If you have no housing, do you live in your car, in a tent or under a bridge or other inappropriate location?

Please explain:

_____

_____

Agency Involvement:

(Are you working with or have you recently worked with any of the following agencies? If so, please provide a caseworker/contact name where applicable. We can better serve your needs when we collaborate with other organizations you are connected with).

Voc Rehab: _____
Probation & Parole: _____
Springfield Supportive Housing: _____
Department for Children & Families: _____
Health Care & Rehabilitation Services/ HCRS: _____
Economic Services/ State of Vermont/ ReachUp: _____
Turning Point/ or Substance Abuse Recovery Program: _____
Community Health Team/ Valley Health Connections: _____

Only 2 household members **over the age of 18** may be claimed on a Food Shelf. *If more individuals over 18 are in the household, they would need to sign up and pick up their own Food Shelf for themselves.*

Household Members (including children):

NAME	GENDER: M/F	DATE OF BIRTH	HEALTH INSURANCE Y/N	CURRENT GRADE LEVEL OR EDUCATION LEVEL	DISABLED Y/N

Income Information:

SOURCE OF INCOME	HEAD OF HOUSEHOLD (income amount/source per month)	SPOUSE or OTHER HOUSEHOLD MEMBER (income amount/ source per month
REACHUP:		
SSI/SSD:		
SOCIAL SECURITY:		
PENSION:		
GENERAL ASSISTANCE:		
UNEMPLOYMENT:		
EMPLOYMENT ONLY:		
DISABILITY:		
OTHER:		
FOODSTAMPS:		
WIC:		
TOTAL MONTHLY INCOME:	$	$
HOUSEHOLD INCOME TOTAL:	$	$

If you have no income, please explain:

_____

_____

I, _____, certify to the best of my knowledge that the information which is provided herein is true and correct. I understand any information I am sharing is strictly confidential. I, _____, give permission for Springfield Family Center executive staff to act as an advocate on my behalf.

Client Name (printed): _____
Client Signature: _____Date: _____