Giving to the Nations – *Healthy Essentials Pantry*
Client Intake Form

OFFICE USE ONLY **Date:** ____________________ ☐ **New Client Certification** ☐ **Client Re-Certification**

Client Number: ______________________ **Processed By:** ______________________________

Please fill out the <u>entire form</u> so we may serve you better

CLIENT DOCUMENTATION

Are you homeless? ☐ Yes ☐ No If no, please complete address portion of form.

How did you hear about *Healthy Essentials Pantry*?

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CLIENT INFORMATION

CLIENT NAME: (PRINT)____

CLIENT ADDRESS:____

CITY:_________________________________ **STATE:**__________ **ZIP CODE:**______________ **COUNTY:**_____________

TELEPHONE NUMBER:_________________________________ **EMAIL:**____

HOUSEHOLD INFORMATION: How many people live in your house in the following age/gender groups and indicate how many are male or female. (Write the numbers in all boxes that apply)

Under 5 yrs:	**5 – 9 yrs:**	**10 – 14 yrs:**	**15 – 19 yrs:**	**20 – 24 yrs:**
Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
25 – 34 yrs:	**35 – 44 yrs:**	**45 – 54 yrs:**	**55 – 64 yrs:**	**65 – 84 yrs:**
Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
85 yrs and over:				
Male ☐ Female ☐				

MILITARY STATUS: (Place an "x" in the appropriate box)

Active Military:	Retired Military:	Reserve/NG Military:	Veteran:

PLEASE SELECT YOUR RACIAL CATEGORY: (Place an "x" in the appropriate box)

White:	Asian:	Black or African American:	American Indian and Alaska Native:
One Race, Other:	Two or More Races:	Native Hawaiian and Other Pacific Islander:	

PLEASE SELECT YOUR ETHNIC CATEGORY: (Place an "x" in the appropriate box)

Hispanic or Latino:	Not Hispanic or Latino:

DOES YOUR FAMILY RECEIVE ANY TYPE OF ASSISTANCE and/or enrolled in any assistance programs? (Place an "x" in all boxes that apply)

FoodShare Wisconsin:	SSI:	SSDI:	CHIP:	SNAP (Food Stamps):	Medicaid:
WIC:	Child Support:		CSFP:	WHEAP:	TANF:

THE TOTAL GROSS INCOME (THE AMOUNT BEFORE DEDICTIONS) OF ALL HOUSEHOLD MEMBER IS: (Identify the family member receiving the income and indicate source of income. Place the amount of income in the box - per year, per month, or per week). If no income, please enter "no income" in this section.

Name:	Income/Source:	Per Year	Per Month	Per Week
Name:	Income/Source:	Per Year	Per Month	Per Week
Name:	Income/Source:	Per Year	Per Month	Per Week
Name:	Income/Source:	Per Year	Per Month	Per Week

Was there an emergency situation which caused you to need personal care or household cleaning products?

☐ **Yes** ☐ **No**

If yes, please state situation	

Are there any other needs you or your family have right now? ☐ **Yes** ☐ **No**

If yes, please state situation	

CLIENT ACKNOWLEDGEMENT

I certify that I am a member of the household listed above, 18 years of age or older, and certify that all information regarding my household is true to the best of my knowledge. I also designate the following person(s) as an authorized representative(s) of my household and certify that their information is correct to the best of my knowledge. Authorized representative(s) is/are able to pick up product for client until re-certification is necessary.

Name of Authorized Representative(s)	**Authorized Representative(s) Address/Phone**
1.	
2.	

Client Signature: ____ Date: _____________________

NOTE: These questions do not determine your ability to receive services. This information is collected for tracking the need for future services and for obtaining additional funding to support our programs.

Please email completed form to: office@givingtothenations.org OR
Mail to: Giving to the Nations
4003 Durand Ave, Ste 5A
Racine, WI 53405

Contact Us: www.givingtothenations.org/contact