San Antonio Food Bank
Partner Agency Pantry Family Intake Form

Form B

Please answer all questions so that we may serve you better. This information will not be shared with any other outside agency or entity others than the San Antonio Food Bank for reporting purposes.

CLIENT DOCUMENTATION (client may fill this out) **Date of Intake: _____**

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

Household Information

YOUR NAME	
ADDRESS	
CITY / STATE/ ZIP/ COUNTY	
PHONE	

How many people live in your house: | | **Are you head of the household?** | **Yes** | | **No** | |

Are you?

African American		Asian		Caucasian		Hispanic		Native American		Other	

How many people live in your house in the following age / gender groups: (please write the number in the box)

0-5 yrs		**6-18 yrs**		**19-40 yrs**		**41-59 yrs**		**60 and over**	
# Males in house				# Females in house					

How many people live in your house in the following groups: (please write the number in the box)

Elderly		**Physically Disabled**		**Abuse Victims**		**Mentally Disabled**		**People with Chronic Illness**	
Homeless		**Military** (active, retired or reserve)						**Other: (specify)**	

Does your family receive any type of assistance? ***Check all that apply***

Temporary Assistance To Needy Families (TANF / AFDC)		**SNAP (Food Stamps)**	
SSI		**Medicaid**	
CHIP		**WIC**	

The Total Gross Income (the amount before deductions) of all household members is:

GROSS INCOME	**$**		**Per Year**		**Per Month**		**Per Week**	

Was there an emergency situation that caused you to need food? **Yes** | | **No** |

If yes, please state situation	

Client Signature **(client must be present for initial interview and food assistance)** **Date**

I certify that I am a member of the household listed above and that on behalf of this household I have applied for USDA Products. I certify that all information regarding my household is true to the best of my knowledge. I also designate the following person as an authorized representative of my household and certify that their information is correct to the best of my knowledge. Authorized representative is able to pick up product for client until re-certification is necessary…

Name of Authorized Representative: (not name of family member only person to act on their behalf)	**Authorized Representatives Address**

AGENCY DOCUMENTATION

Family Name:_____ Date: _____

☐ **Household is INELIGIBLE**: (clients denied USDA products should be referred to the SAFB for review)

- ☐ Income level over 185% listed on Annual Income Guidelines
- ☐ Is not an emergency situation and does not meet any other criteria
- ☐ Other:_____

☐ **Household is ELIGIBLE based on**:

- ☐ **Low Income** (Enter certification period below; sign and date the form at the bottom)
- ☐ **Emergency Food Need** (Describe emergency need in "Comments" section; enter "Certification Period;" sign and date the form, clients in this category may be served no more than 6 months unless another emergency can be documented.)
- ☐ **Receipt of TANF/AFDC** (Enter the "Certification Period;" sign and date the form.)
- ☐ **Receipt of Food Stamps** (Enter "Certification Period;" sign and date the form.)
- ☐ **Receipt of SSI** (Enter the "Certification Period;" sign and dater the form.)
- ☐ **Receipt of Medicaid** (Enter the "Certification Period;" sign and date the form."

Certification Period: Start Date: _____ End Date: _____

Comments:

Agency Staff Initials: _____ Revisit this form on: _____

Please have client sign every time they come receive assistance
(if you have another form for this that is fine, but you must keep all documentation accessible and together)

Date	Signature of Client (by client)