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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 Are you he Househole	omele	ss? [] Yes			may Io	fill thi			plea	Date o se complete	f Intake:		of for	m.	_
YOUR	NAM	E														
ADDF	RESS															
CITY / STA COUN		P/														
РНО	NE															
How many Are you?	peop	le live	e in you	ır hou	ise:			Are	you]	nead	of the house	ehold?	Yes	No		
African American		As	ian		Caucasian		Hisp	oanic		ľ	Native American		Other			
How many	peop	le live	e in you	ır hou	se in the f	ollow	ing age	e / gei	nder	group	os: (please	write the n	umber i	in the	box)	
0-5 yrs			6-18	yrs		19	-40 yrs	5		4	41-59 yrs		60 and	over		
# Ma	les in	hous	e						# F	emal	es in house					
How many	peop	le live	e in you	ır hou	se in the f	ollow	ing gro	oups:	(plea	ase w	rite the nun	nber in the	e box)			
Elderly		Phy	sically abled		Abuse Victims		Ment Disat	ally			ple with Chro					
Homele	SS			N	Ailitary (ac rese	ctive, r erve)	etired o	•			Other: (sp	ecify)				
Does your	family	v rece	eive any	v type	of assistar	nce?	chec.	k all t	hat ap	ply						
Temporary	Assist	ance T	o Needy	Famili	ies (TANF / A	AFDC))					SNAP	(Food	Stam	ps)	
						SSI								Medi	caid	
						CHIP								V	VIC	
The Total G	ross I	ncome	e (the ar	nount	before dedi	uction	s) of all	hous	ehold	mem	bers is:					
GROSS INCOME	\$								er Ye			Per Month		Pe	r Wee	k
Was there	an em	erge	ncy situ	ation	that cause	ed you	u to ne	ed fo	od?	Yes	No					
If yes, please s	state situ	ation														

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

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AGENCY DOCUMENTATION

Family Name:	Date:
 Household is INELIGIBLE: (clients denied USDA point income level over 185% listed on Annual Income Guidelines Is not an emergency situation and does not meet any other criter Other: 	ia
Household is ELIGIBLE based on: Low Income (Enter certification period below; sign and da	te the form at the bottom)
Emergency Food Need (Describe emergency need in "Co clients in this category may be served no more than 6 mon	omments" section; enter "Certification Period;" sign and date the form, ths 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;" sig	gn and date the form.)
Receipt of SSI (Enter the "Certification Period;" sign and	dater the form.)
Receipt of Medicaid (Enter the "Certification Period;" sig	gn 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)						

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