All Documents Must be Emailed to clientdocs@cahra.org or Faxed to 520-466-0013 three days prior to your appointment.

#### COMMUNITY ACTION HUMAN RESOURCES AGENCY

109 N. SUNSHINE BLVD., ELOY, ARIZONA 85131
TEL#(520)466-1112 TOLL FREE 1-877-472-2472~FX#(520)466-0013

CLIENT NAME: HH ID#: C/

CAHRA CLIENT FILE LABEL

A.K.A. APP DATE:

CSM/ID#

## **CLIENT INFORMATION INTAKE FOR SERVICES FORM**

WORKER ID:	S	ITE CODE:		DO YOU	U LIVE IN <b>PINAL</b> COUNT (PLE <i>i</i>	Y? YES Ase chech		TODAY'S DATE:					HOME PHONE # (LAND LINE)				
APPLICANT'S NAME [LAST, FIRST, M.I.]:						SSN:					CELL #						
STREET ADDRESS,	•						<u> </u>	EMERGENCY EMERGENCY									
CITY, ZIP CODE:  PHONE #																	
MAILING ADDRESS (IF DIFFERENT)																	
~~~~~~PLEASE CHECK EVERYTHING THAT APPLIES TO YOU:~~~~~~																	
HOUSING CHECK	BELOW G TYPE:		CHECK BETO				CK BELOW IF ANY SEHOLD MEMBER IS:			LOW HO		CHECK BELO		CHECK BELOW HOME SOURCE OF COOLING:			
☐ OWN		SINGL			NON-RELATED ADULTS		ANT FARMWORKER	HOU		BOAR		<b>□</b> GAS	□W00D	EVAPORATIVE COOLER			
RENT			DULTS NO CHILDRI		CHILDREN	HOM			RTMENT	SHELT			COAL	☐ AIR CONDITIONING	MORTGAGE	FORECLOSURE	
OTHER PERMANE	ENT HOUSING		E SINGLE PAREN	<u> </u>	MULTI GENERATIONAL		WORKER (NOT MIGRANT)		NHOUSE		ON 8 HOUSE	PROPANE	OTHER		MOTEL NIGHT	UTILITY	
HOMELESS	IG W/FAMILY/FRIENDS		SINGLE PARENT PARENT HOUSEH	חום חום	HOUSEHOLD OTHER	\SEAS	ONAL FARMWORKER ONLY	l	LEX LEX	SUBSI	ENTIONAL	ELECTRIC			UTILITY DEPOSIT	ASSISTANCE	
PUBLIC HOUSING		Пімо	TAKENI HUUSEN	ים עוני	VITER				ILE HOULE	10031	וטוצבט				VINEN.		
			1 11	6.1			<del> </del>	Ш,	,		I =				16 1		
					above types of as es, please list belo		e by any church, a	gency, t	amily or	other				me? YES  NO		r home need	
)ate:	III the last 14 h	10111113. 1	Date:	<u> </u>	es, pieuse list beit		Date:				Repairs Ne			ii yes, piedse list be			
_			Organizati	on			Organization										
			Name:				Name:										
ssisted With:			Assisted W	ith:			Assisted With:										
Assistance Amt: _	\$		Assistance	Amt:	\$		Assistance Amt: \$										
LANGUAGE: ENGLIS	SH SPANISH	OTHER	: 🗌	NUMBER	IN HOUSEHOLD:		NUMBER EMPLOYED:		MONTHLY RENT   MORTGAGE:   COST: \$			ST: \$	T: \$ MONTHLY UTILITIES (all): \$				
INCOME INFORMATION DR	IOD 20 DAYS FROM ADDITION	ON DATE (INCLUDE	NC ADDICATION DATE)				(SHADED AREA BE	LOW FOI	R OFFICE	USE)							
(30 <sup>th</sup> DAY):	IOR 30 DAYS FROM APPLICATION	UN DATE (INCLUDI	NO AFFLICATION DATE):			TO APPLIC	ATION DATE:										
TYPE OF	WAGES / SALARY		2		RETIRE/PENSION		\$	AHCC	CCSRX DISC	COUNT CA	ARD			se note that			
INCOME	SELF EMPLOYMENT	Ī	<u>\$</u>		DIV/INTEREST		\$	WIC.	FOODBOX	? Y or	N			ıment does r			
FOR	UNEMPLOYMENT		<u>\$</u>		VETERAN BENEFITS			DATE	RECEIVED:				assis <sup>,</sup>	tance. You i	must be eli	gible for	
LAST 30	WORKMAN'S COMP	•	<u>\$</u>		NO INCOME		<u>\$</u>	HOUS	SING SUBSID	YTAP.	LIFELINE	. STDP	the p	rogram to q	ualify. If yo	ou are	
DAYS	ALIMONY/CHILD SU	JPPORT	\$				<u>\$</u>	UTILI	ITY DISCOUN	NT PROGR	RAMS ENROLLE	D IN:	com	pleting this fo	orm online	, please	
(GROSS	CASH ASSISTANCE		<u> </u>		TOTAL INCOME:		<u>\$</u>	APS-I	E3SWG-	LIRA	. SRP		call the office at 520-466-1112 to				
ONLY-	GRANT DIVERSION		<u>\$</u>		<del>-</del>	THER RES	<u>OURCES</u>		ME TAX RE	FUND REC	CEIVED:		request an appointment prior to				
NOT TAKE	SOCIAL SECURITY		_		Circle programs you	receive:		Υo	r N				_	pleting this d			
HOME)			<u>\$</u>		FOOD STAMPS \$			DATE	:	AM	1T \$			J			
,	SSI		<u>\$</u>		If no, have you app	lied? Y	or N DAIE:										

#### HOUSEHOLD MEMBERS INFORMATION

EDUCATION	RACE/ETHNICITY	MEDICAL INSURANCE	DISABILITY STATUS	EMPLOYMENT STATUS	MARITAL STATUS	RELATION TO HEAD OF HOUSEHOLD
0=0-8 <sup>TH</sup> GRADE	AS=ASIAN	MA=MEDICAID/AHCCCS	C=COGNITIVE	F=FULL TIME	N=NEVER MARRIED/SINGLE	H=HEAD OF HOUSEHOLD
9=9-12 <sup>TH</sup> GRADE(NON-GRAD)	N=NATIVE HAWAIIN/OTHER PAC ISLANDER	MC=MEDICARE	H=HEARING	P=PART TIME	M=MARRIED	S=SPOUSE
H=HIGH SCHOOL GRAD/GED	B=BLACK/AFRICAN AMERICAN	SC=STATE CHIP	D=DEAF	M=MIGRANT SEASONAL	S=SEPARATED	C=CHILD
12=12+SOME POST SEC	W=WHITE	SI=STATE INS FOR ADULTS	S=SPEECH	UL=UNEMPLOYED 6 MTH OR LESS	D=DIVORCED	F=FOSTER CHILD
2=2 YR COLLEGE GRADUATE	AA=AMERICAN INDIAN OR ALASKA NATIVE	M=MILITARY	V=VISIUAL	UP=UNEMPLOYED 6 MTH PLUS	W=WIDOWED	GC=GRANDCHILD
4= 4 YR COLLEGE GRADUATE	AM=AMERICAN INDIAN OR ALASKA NATIVE & WHITE	DP=DIRECT PURCHASE	M=MENTAL ILLNESS	UN=UNEMPLOYED-NOT IN LABOR		P=PARENT
GP=GRADUATE OF OTHER POST-		EB=EMPLOYMENT BASED	0=ORTHOPEDIC	FORCE		GP=GRANDPARENT
SECONDARY SCHOOL	AW=ASIAN & WHITE	N=NO HEALTH INSURANCE	OT=OTHER	R=RETIRED	VETERAN STATUS	O=OTHER RELATION
	BO=BLACK OR AFRICAN AMERICAN & WHITE	IH=INDAIN HEALTH INS	N=NONE	C=CONTRACT	V=VETERAN	NR=NOT RELATED
CITIZENSHIP STATUS	AI=AMERICAN INDAIN OR ALASKA NATIVE & BLACK OR	CLIENT NAME:		T=TEMPORARY	A=ACTIVE MILITARY	AC=ADULT CHILD
U=US BORN/NATURALIZED	AFRICAN AMERICAN		LIENT FILE LABEL	13=13 YRS OR YOUNGER	N=NO MILITARY	
E=ELIGIBLE LEGAL RESIDENT	M=MULTI RACIAL	A.K.A.			BACKGROUND	
NE=NON-ELIGIBLE LEGAL RES	H=HISPANIC OR LATINO OR SPANISH ORIGIN	APP DATE: C	SM/ID#			
I=ILLEGAL RESIDENT	0=OTHER			DISCONNECTED YOUTH STATUS:	ndividuals ages 14 thru 24 wh	o are not employed or are not attending school

BELOW	PLEASE F	ILL OUT INFO	RMATION FOR ALL HOUSEHOLD MEMBERS (	EACI	H):	105	FRUCI	CITIZEN	D.L.C.F.	MEDICAL	DICADILITY	EMBI OV	MARITAL	DEI ATION	VETERAN	DICCON	DDEC
SOCIAL	SECURITY	NUMBER	(LAST NAME, FIRST NAME, MIDDLE INITIAL)	G E N D E R	BIRTHDATE	AGE	EDUCA TION	STATUS	RACE	INSUR- ANCE TYPE	(PLEASE	MENT STATUS:	STATUS	TO HEAD OF HOUSE HOLD	STATUS	DISCON- NECTED YOUTH Y or N	NANT TEEN
I) APPLICANT				M F													
2)				M F													
3)				M													
4)				M F													
5)				M F													
6)				M F													
7)				M F													
8)				M F													
9)				M F													
10)				M F													
11)				M F													
12)				M F													
13)	 KE FOR SERVICES FORM- I			M F													

# COMMUNITY ACTION HUMAN RESOURCES AGENCY 109 N. SUNSHINE BLVD, ELOY, ARIZONA 85131 / PH# (520)466-1112

FAX# (520)466-0013

What happened that made it difficult for you to pay for your needs and request assistance?						
How will you take care of these needs next mont	<u>h?</u>					
APPLICANT SIGNATURE:	DATE:					
If your benefits have been sanctioned, you may n	ot qualify for the assistance.					
	BELOW FOR OFFICE USE ONLY:					
	CLIENT NAME:					
	HH ID#: CAHRA CLIENT FILE LABEL A.K.A. APP DATE: CSM/ID#					

## COMMUNITY ACTION HUMAN RESOURCES AGENCY 109 N. SUNSHINE BLVD., ELOY, ARIZONA 85131 / PH# (520)466-1112 FAX# (520)466-0013

#### PLEASE READ AND SIGN THE FOLLOWING STATEMENT:

I swear and affirm that the information on this form is true and correct to the best of my knowledge. With my signature below, I also affirm that I understand that CAHRA is a delegate agency/contract designee of the State of Arizona and the Arizona Department of Economic Security (reference application Statement of Truth).

I understand that the information provided will become a permanent file with access limited to representatives of CAHRA and that no information obtained from this form and/or application shall be made public in such a manner that my dwelling or household can be identified.

I understand that I may request a Fair Hearing orally or in writing if I disagree with any action taken on my case. I understand that anyone who violates the provisions of the Low Income Energy Assistance and/or Community Services Programs or knowingly provide false information in any report require under it, may be fined not more than \$10,000 or imprisoned no more than five years or both (Chapter II, Title 45 cfr 260.3541).

DATE:\_\_\_\_\_

DATE:

APPLICANT SIGNATURE:

CASE MANAGER SIGNATURE:

CASE MANAGER SIGNATURE:

I confirm that the Home Energy-Savings Checklist Brochure provide	ded to me was reviewed with me.
APPLICANT SIGNATURE:	DATE:

**CLIENT NAME:** 

HH ID#: CAHRA CLIENT FILE LABEL

A.K.A.

APP DATE: CSM/ID#



## Community Action Human Resources Agency

109 N. SUNSHINE BLVD. ~ Eloy, Arizona 85131 / Phone: 520/466-1112 ~ Fax: 520/466-0013

### AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

l,		, understand that it may be necessary for
	(Client Name/Please Print) HTY ACTION HUMAN RESOURCES AGENCY (CAHRA make me eligible for assistance I have requested	and/or authorized agents to obtain information from other agencies and entities.
Accordingly,	I authorize and request any public, government	al or private institution and its authorized agents including, but not limited to:
* *	Other Social Services agents Military personnel Physicians Utility companies Hospitals Governments	<ul> <li>Employers</li> <li>Credit Bureaus</li> <li>Landlords &amp; their agents</li> <li>Advocacy agencies</li> <li>Social Security Administration</li> </ul>
personnel and	d employment records, military records, credit reco	mation which it may request in the form of oral or written reports, opinions, findings, rds, all medical records, statement of charges, or rental records regarding any incident o, or about which you may have rendered services and/or consultation.
Please provide the	e following information to CAHRA:	
	RSIGNED Client, also understand that it may be authorized sources to other assistance programs	necessary for CAHRA, or its authorized agents to release information obtained in order to obtain assistance through CAHRA.
•	reby waive any privilege I have to this informat out written authority from me (pursuant to privi	ion to CAHRA, you are further requested to disclose no information to any other lege and confidential communication statutes).
A photostation	c copy, fax copy, or other chemical reproduction	of this authorization shall serve in its stead.
THIS CONSEN	IT, UNLESS EXPRESSLY REVOKED EARLIER, Expire	s upon:
		(Specify date, event, or condition upon expiration)
Client Signat	ure:	
Social Securi	ty #:	(Date)  Date of Birth:
Parent/Guard	dian or Legal Representative Signature:	(Date)
Case Manage	r Signature:	
Case Manage	r Name/ID#:	1
		(Please Print)

CLIENT INFORM INTAKE FOR SERVICES FORM- Updated 2/5/2024

## OTHER ADULT IN HOUSEHOLD

## Community Action Human Resources Agency

/

109 N. SUNSHINE BLVD. ~ Eloy, Arizona 85131

Phone: 520/466-1112 ~ Fax: 520/466-0013

(Please Print)

## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

(Client Name/Please Print)	, understand that it may be necessary for
the COMMUNITY ACTION HUMAN RESOURCES AGENCY (CAHRA	) and/or authorized agents to obtain information from other agencies and entities
in order to make me eligible for assistance I have requested	l.
Accordingly, I authorize and request any public, government	al or private institution and its authorized agents including, but not limited to:
<ul> <li>Other Social Services agents</li> <li>Military personnel</li> </ul>	<ul><li>◆ Employers</li><li>◆ Credit Bureaus</li></ul>
♦ Physicians	◆ Landlords & their agents
<ul><li>Utility companies</li><li>Hospitals</li></ul>	<ul><li>◆ Advocacy agencies</li><li>◆ Social Security Administration</li></ul>
◆ Governments	, , , , , , , , , , , , , , , , , , , ,
· ,	rmation which it may request in the form of oral or written reports, opinions, findings
· · · · · · · · · · · · · · · · · · ·	ords, all medical records, statement of charges, or rental records regarding any incident to, or about which you may have rendered services and/or consultation.
, ,	to, or about which you may have rendered services and/or consultation.
Please provide the following information to CAHRA:	
I, THE UNDERSIGNED Client, also understand that it may be	necessary for CAHRA, or its authorized agents to release information obtained
from me to authorized sources to other assistance programs	,
Though I hereby waive any privilege I have to this informat	ion to CAHRA, you are further requested to disclose no information to any other
person without written authority from me (pursuant to privi	<i>,</i>
A photostatic copy, fax copy, or other chemical reproduction	of this authorization shall sorve in its stead
A photostatic copy, lax copy, or other chemical reproduction	of this authorization shall serve in its stead.
THIS CONSENT, UNLESS EXPRESSLY REVOKED EARLIER, Expire	
	(Specify date, event, or condition upon expiration)
Client Signature:	
Social Security #:	(Date)  Date of Birth:
•	Date of Birth.
Parent/Guardian or Legal Representative Signature:  (circle relationship to client)	(Date)
Case Manager Signature:	(vaie)
Case Hanager Signature.	
Case Manager Name/ID#:	

CLIENT INFORM INTAKE FOR SERVICES FORM- Updated 2/5/2024

#### COMMUNITY ACTION HUMAN RESOURCES AGENCY (CAHRA)

109 N. SUNSHINE BLVD., ELOY, AZ 85131 ~ TEL# (520)466-1112 / TOLL FREE# (877)472-2472 / FAX# (520)466-0013

## Case Management Program Participation Agreement (APPLICANT PLEASE READ/SIGN)

The most important service CAHRA provides is case management. <u>Financial assistance is part of a case management plan.</u>
If you do not participate in case management, we may not assist you, or how assistance is provided may be affected. If you agree to participate in case management and then do not complete your case plan, we may choose to provide no further assistance to your household.

#### ♦ Why can't you just pay my bill?

We have learned that not having enough money to pay your bills is not always the "real" problem. Something is happening that causes you not to have enough money to pay your bills — and together we need to figure out what that is. Once we know why, then we can figure out ways to make sure the same problem doesn't keep happening.

#### ♦ How are you going to figure out why I need money?

First we want to talk to you about your household in general. And, in working with you, we are going to complete a self-sufficiency matrix. The matrix tells us how well you and your family, are able to meet basic needs. You will be a partner in each activity. We are not going to tell you about your situation. We will discuss it together. You and the case manager will come up with answers that you both agree on. We want the opportunity to do things with you — not for you or to you.

#### ♦ What happens next?

We are going to offer you and your family the opportunity to enter into our case management program. That means that you and the case manager are going to talk about what changes you want to make, like going back to school, finding a better job, getting counseling. You and your case manager will come up with ways to make the changes you want. It might take up to six months, but your case manager will work with you during all that time.

#### ♦ When do I get money to pay my bills?

We want to make sure that you don't lose your utility service or get evicted. But, we also want to make sure that you and your household are going to take action so that you will correct whatever is causing your problems. Creating your case management plan is always the first step. Paying your bills is a part of that process. If necessary, we will try to help you get extensions on your bills until we can arrive at a decision about the best way to help you.

#### ◆ Don't you have to pay my bills?

None of the funds provided to us are "entitlement" dollars. This means that we have the final decision whether or not assistance is provided. And that decision is based on whether or not you participate in case management.

#### ♦ Why wouldn't you want to help me?

Helping doesn't always mean paying your bill. If we don't pay your bill, we will try to help you solve the problems in some other ways. Sometimes the best way to help a family is working with you to find a better job, get more education, or to help solve some problems that are keeping you from working or taking care of your family.

#### ◆ What happens if I don't complete my case management plan?

The case management plan is an agreement between you and your case manager and this Agency. Just like a contract, each party agrees to fulfill specific obligations. If your case manager does not follow through or if you have concerns about how your case manager is working with you, you have the right to file a complaint with the Community Services Manager. If you do not follow through with your part of the case management plan, then we may choose not to assist you in the future.

It is to your advantage to work with your case manager to complete the goals and objectives that you both develop. It will ensure that if you have a financial shortfall while you are working on your plan, you can be assisted. It will also help to insure a better life for you and your family.

I have read, understand and agree to participate in the case management plan program above:

APPLICANT SIGNATURE: DATE

CLIENT NAME:

HH ID#: CAHRA CLIENT FILE LABEL

A.K.A.

APP DATE: CSM/ID#

#### COMMUNITY ACTION HUMAN RESOURCES AGENCY (CAHRA)

109 N. SUNSHINE BLVD., ELOY, AZ 85131 ~ TEL# (520)466-1112 / TOLL FREE# (877)472-2472 / FAX# (520)466-0013

Case Management Program Participation Agreement (APPLICANT PLEASE READ/SIGN)

The most important service CAHRA provides is case management. <u>Financial assistance is part of a case management plan.</u>
If you do not participate in case management, we may not assist you, or how assistance is provided may be affected. If you agree to participate in case management and then do not complete your case plan, we may choose to provide no further assistance to your household.

#### ♦ Why can't you just pay my bill?

We have learned that not having enough money to pay your bills is not always the "real" problem. Something is happening that causes you not to have enough money to pay your bills — and together we need to figure out what that is. Once we know why, then we can figure out ways to make sure the same problem doesn't keep happening.

#### ♦ How are you going to figure out why I need money?

First, we want to talk to you about your household in general. And, in working with you, we are going to complete a self-sufficiency matrix. The matrix tells us how well you and your family, are able to meet basic needs. You will be a partner in each activity. We are not going to tell you about your situation. We will discuss it together. You and the case manager will come up with answers that you both agree on. We want the opportunity to do things with you — not for you or to you.

### **♦ What happens next?**

We are going to offer you and your family the opportunity to enter into our case management program. That means that you and the case manager are going to talk about what changes you want to make, like going back to school, finding a better job, getting counseling. You and your case manager will come up with ways to make the changes you want. It might take up to six months, but your case manager will work with you during all that time.

## ♦ When do I get money to pay my bills?

We want to make sure that you don't lose your utility service or get evicted. But, we also want to make sure that you and your household are going to take action so that you will correct whatever is causing your problems. Creating your case management plan is always the first step. Paying your bills is a part of that process. If necessary, we will try to help you get extensions on your bills until we can arrive at a decision about the best way to help you.

## ♦ Don't you have to pay my bills?

None of the funds provided to us are "entitlement" dollars. This means that we have the final decision whether or not assistance is provided. And that decision is based on whether or not you participate in case management.

## ♦ Why wouldn't you want to help me?

Helping doesn't always mean paying your bill. If we don't pay your bill, we will try to help you solve the problems in some other ways. Sometimes the best way to help a family is working with you to find a better job, get more education, or to help solve some problems that are keeping you from working or taking care of your family.

## ♦ What happens if I don't complete my case management plan?

The case management plan is an agreement between you and your case manager and this Agency. Just like a contract, each party agrees to fulfill specific obligations. If your case manager does not follow through or if you have concerns about how your case manager is working with you, you have the right to file a complaint with the Community Services Manager. If you do not follow through with your part of the case management plan, then we may choose not to assist you in the future.

It is to your advantage to work with your case manager to complete the goals and objectives that you both develop. It will ensure that if you have a financial shortfall while you are working on your plan, you can be assisted. It will also help to insure a better life for you and your

family. APPLICANT CO

## EMPLOYER/SOURCE DETAIL INFORMATION:

		HH ID#: CAHRA CLIENT FILE LABEL
Employee / Member Name:		A.K.A. APP DATE: CSM/ID#
Employer/Source Name:		•
Employer/Source Phone Number:		
Employer/Source Address:		
	Street / Mail Address	
	City State	Zip Code
2 Employee / Member Name:		
Employer/Source Name:		
Employer/Source Phone Number:		
Employer/Source Address:		
	Street / Mail Address	
	City State	Zip Code
3 Employee / Member Name:		
Employer/Source Name:		
Employer/Source Phone Number:		
Employer/Source Address:		
	Street / Mail Address	
	City State	Zip Code
Employee / Member Name:		
Employer/Source Name:		
Employer/Source Phone Number:		
Employer/Source Address:		
	Street / Mail Address	
	City State	Zip Code

#### COMMUNITY ACTION HUMAN RESOURCES AGENCY 109 N. SUNSHINE BLVD., ELOY, ARIZONA 85131 ~ TEL# (520)466-1112 / (877)472-2472 ~ FAX# (520)466-0013

NEEDS VEDSUS DESCUIDEES . To be completed by applicant ... AND TO BE DEVIEWED AND COMPLETED BY CASE MANAGED AND ADDITIONAL TOGETHED

GROSS INCOME RECEIVED		OTHER MONIES/FUNDS/RESOU		t ~ <b>AND</b> to be reviewed and <b>Paid Expenses and other D</b>	EDUCTIONS	THESE ARE EXPENSES YOU CURRENTLY	HAVE AND		
HOUSEHOLD MEM		BY <b>ALL/ANY</b> HOUSEHOLD		(MAY NEED TO PROVIDE R		<u>DO NOT</u> HAVE THE FUNDS/MONIES,			
(PAST 30 DAYS	5)	(PAST 30 DAYS)	)	(PAST 30 DAYS)	,	TO PAY FOR THESE EXPENSE	<u>S</u>		
COLUMN A		COLUMN B		COLUMN C		COLUMN D			
WAGES/SALARY	\$	FOODSTAMPS	\$	RENT/MORTGAGE <i>(PAID)</i>	\$	RENT/MORTGAGE <u>(NEED TO PAY</u> )	\$		
UNEMPLOYMENT	\$	CASH IN BANK	\$	ELECTRIC <u>(PAID)</u>	\$	ELECTRIC <u>(NEED TO PAY)</u>	\$		
CHILD SUPPORT	\$	CASH ON HAND	\$	GAS <u>(PAID)</u>	\$	GAS <u>(NEED TO PAY)</u>	\$		
CASH ASSISTANCE/ TANF	\$	EMERGENCY SAVINGS	\$	PROPANE <u>(PAID)</u>	\$	PROPANE <u>(NEED TO PAY)</u>	\$		
BENEFIT		LONG TERM SAVINGS	\$	WATER <u>(PAID)</u>	\$	WATER <u>(NEED TO PAI</u> )	\$		
ALIMONY	\$		\$	GARBAGE/SEWER ( <u><i>PAID)</i></u>	\$	GARBAGE/SEWER (NEED TO PAY)	\$		
PENSION	\$	RENT VOUCHER/STIPEND	\$	TELEPHONE ( <u>PAID)</u>	\$	TELEPHONE (NEED TO PAY)	\$		
VETERAN'S BENEFITS	\$	UTILITY VOUCHER/STIPEND	\$	GROCERIES <u>(PAID)</u>	\$	GROCERIES (NEED TO PAY)	\$		
SOCIAL SECURITY	\$	GASOLINE STIPEND/VOUCHER	\$	MEALS OUT/FAST FOOD <i>(PAID</i>	\$	MEALS OUT/FAST FOOD <u>NEED TO PAY</u> )	\$		
SOCIAL SECURITY	\$	WIC (APPROXIMATE VALUE)	\$	AUTO/LEASE PAYMENT <i>(PAID</i> )	\$	AUTO/LEASE PAYMENT (NEED TO PAY)	\$		
DISABILITY		EDUCATIONAL GRANT	\$	AUTOMOBILE INSURANCE ( <i>PAID</i> )	\$	AUTO INSURANCE <u>(NEED TO PAY)</u>	\$		
SUPPLEMENTAL SOCIAL	\$	INCOME TAX REFUND	\$	AUTO REGISTRATION (PAID)	\$	AUTO REGISTRATION (NEED TO PAY)	\$		
SECURITY		EMPLOYEE FUND	\$	AUTO PARTS/REPAIR (PAID)	\$	AUTO PARTS/REPAIR (NEED TO PAY)	\$		
WORKER'S COMPENSATION	\$	AGENCY	\$	AUTO FUEL/TRANSPORTATION (PAID)	\$	AUTO FUEL/TRANSPORTATION (NEED TO PAY)	\$		
OTHER	\$	AGENCY	\$	OIL FOR AUTO <i>(PAID)</i>	\$	OIL FOR AUTO( <u>NEED TO PAY)</u>	\$		
OTHER	\$	AGENCY	\$	CHILD CARE/DES CO FEE (PAID)	\$	CHILD CARE/DES CO FEE (NEED TO PAY)	\$		
OTHER	\$	ORGANIZATION	\$	CHILD SUPPORT/ALIMONY <i>(PAID</i> )	\$	CHILD SUPPORT/ALIMONY (NEED TO PAY)	\$		
OTHER	\$	ORGANIZATION	\$	DOCTOR VISIT <i>(PAID)</i>	\$	DOCTOR VISIT (NEED TO PAY)	\$		
OTHER	\$	OTHER	\$	PRESCRIPTIONS (PAID)	\$	PRESCRIPTIONS <u>NEED TO PAY)</u>	\$		
OTHER	\$	OTHER	\$	MEDICAL INSURANCE (PAID)	\$	MEDICAL INSURANCE (NEED TO PAY)	\$		
TOTAL	•	TOTAL		OTHER MEDICAL EXPENSES (PAID)	\$	Other MEDICAL EXPENSES (NEED TO PAY)	\$		
INCOME\$		<b>RESOURCES\$</b>		PERSONAL CARE/ITEMS (PAID)	\$	PERSONAL CARE/ITEMS (NEED TO PAY)	\$		
NOTES:				CLOTING/UIFORMS <i>(PAID)</i>	\$	CLOTHING/UNIFORMS (NEED TO PAY)	\$		
				DRY CLEANING/LAUNDRY <i>(PAID)</i>	\$	DRY CLEANING/LAUNDRY (NEED TO PAY)	\$		
				Other: (PAID)	\$	Other: (NEED TO PAY)	\$		
				<del></del>	\$	Other: (NEED TO PAY)	\$		
				' '	7	1 /			
				Other: (PAID)	\$	Other: (NEED TO PAY)	\$		
				TOTAL EXPENSES(PAID)\$		TOTAL EXPENSES (NEED TO PAY)\$			
<u>FOR OFFICE USE ON</u>	ILYTOTAL	COLUMNS A + B = \$		MINUS TOTAL OF COLUM	1N C = + / -	\$ UNMET NEEDS			

		Other:	(PAID)	\$	Other:		(NEED TO PAY)	\$
		Other:  TOTAL EXPENSES	<u>(PAID)</u> (PAID)\$	3	Other:	(PENSES (NEED	(NEED TO PAY)  TO PAY)\$	\$
FOR OFFICE USE ONLYTOTAL COLUMNS A + B = \$		MINUS TOTA	L OF COLUM	1N C = + / - \$		UNMET NI	EEDS	
Applicant Signature Date  LIENT INFORM INTAKE FOR SERVICES FORM- Updated 2/5/2024	_/	Case Manager Signatu	ire		Date	CLIENT NAME HH ID#: A.K.A. APP DATE:	E: CAHRA CLIEN' CSM/ID#	