

APPLICANT INFORMATION

Name		Date App Rec'd
Campus/Entity	Position	SSN
Years Worked for Providence	HHF Prior Use? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, when?</i> _____	
Steps Already Taken <input type="checkbox"/> Payment Plan <input type="checkbox"/> Short-term loan <input type="checkbox"/> Retirement Funds <input type="checkbox"/> Medical Charity Care <input type="checkbox"/> Borrow from family <input type="checkbox"/> Community / Religious <input type="checkbox"/> Credit Counseling <input type="checkbox"/> Borrow from friends <input type="checkbox"/> Other _____		
Emergency Need		<input type="checkbox"/> See Attached

FINANCIAL ASSISTANCE

FOOD TOTAL	\$
HOUSING TOTAL	\$
<input type="checkbox"/> Rent	\$
<input type="checkbox"/> Mortgage	\$
UTILITIES TOTAL	\$
<input type="checkbox"/> Electricity	\$
<input type="checkbox"/> Heating	\$
<input type="checkbox"/> Water/Sewer	\$
<input type="checkbox"/> Garbage	\$
<input type="checkbox"/> Phone	\$
<input type="checkbox"/> Internet/Media	\$
MEDICAL TOTAL	\$
<input type="checkbox"/> Medical Bills	\$
<input type="checkbox"/> Prescriptions	\$
<input type="checkbox"/> Dental	\$
TRANSPORT. TOTAL	\$
<input type="checkbox"/> Car Repair	\$
<input type="checkbox"/> Car Payment	\$
<input type="checkbox"/> Insurance	\$
<input type="checkbox"/> Gas/Fuel Cards	\$
OTHER:	\$
GRAND TOTAL	\$

DETERMINATION

☐ **ELIGIBLE** Emergency: _____

☐ **INELIGIBLE** Reason: _____

Status & Contact Log	FW Class	Assistance Timeline
	<input type="checkbox"/> Offered	<input type="checkbox"/> Immediately
	<input type="checkbox"/> Required	<input type="checkbox"/> After FW Class
	<input type="checkbox"/> Waived	<input type="checkbox"/> Only _____ Now

FINANCIAL WELLNESS CLASS

<input type="checkbox"/> SEMINAR	Class Date: _____	Class Completed? <input type="checkbox"/>
<input type="checkbox"/> ONLINE	Date Login Info Sent: _____	

For electronic tracking a dot (•) signifies initial entry in the system. A checkmark (✓) signifies completion of post service data entry.

- ☐ Employment Verified
- ☐ Entered in Salesforce
- ☐ Follow up Email Sent

REFERRALS PROVIDED

- | | |
|--|---|
| <input type="checkbox"/> CC Counseling | <input type="checkbox"/> Medical/Dental/Rx |
| <input type="checkbox"/> CC Financial Svcs | <input type="checkbox"/> Diagnosis-Specific |
| <input type="checkbox"/> CC Homeless Svcs | <input type="checkbox"/> Medical Bills |
| <input type="checkbox"/> CC Pregnancy | <input type="checkbox"/> Foreclosure |
| <input type="checkbox"/> CC Spanish Svcs | <input type="checkbox"/> Homeless |
| <input type="checkbox"/> CC Taxes | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Food | <input type="checkbox"/> Rent Well |
| <input type="checkbox"/> Clothing | <input type="checkbox"/> Holiday |
| <input type="checkbox"/> Furniture/Items | <input type="checkbox"/> School Supplies |
| <input type="checkbox"/> Food Stamps | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Local Resources | |
| <input type="checkbox"/> DV Resources | |
| <input type="checkbox"/> Financial Svcs | |
| <input type="checkbox"/> Legal | |

UNIVERSAL INTAKE



PRIMARY CLIENT

First Name		Middle Name		Last Name		Date of Birth	
Social Security Number							
What is your household type? <input type="checkbox"/> Single Person <input type="checkbox"/> Single Mother <input type="checkbox"/> Single Father <input type="checkbox"/> Two parent family <input type="checkbox"/> Grandparent(s) with children <input type="checkbox"/> Foster parent(s) <input type="checkbox"/> Couple with no children <input type="checkbox"/> Other: _____							
How many are in your household (including yourself)?				What primary language is spoken at home?			
Email Address							
Main Phone		Type		2nd Phone		Type	
Ok to leave message?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not call		Ok to leave message?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not call	
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Other Gender: _____							
Cultural Heritage <input type="checkbox"/> African <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Middle Eastern <input type="checkbox"/> White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Slavic <input type="checkbox"/> Other: _____							
What Languages do you speak?				Country of Origin (if other than US)			
Health Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> None <input type="checkbox"/> OHP <input type="checkbox"/> OHP Plus <input type="checkbox"/> Private <input type="checkbox"/> VA							
Are you a US Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No							
What is your employment status? <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Job Training Program <input type="checkbox"/> Irregular Employment <input type="checkbox"/> Not Employed, Not Seeking <input type="checkbox"/> Not Employed, Seeking <input type="checkbox"/> Retired <input type="checkbox"/> On Call <input type="checkbox"/> Other: _____							
What is your highest level of education? <input type="checkbox"/> Less than high school <input type="checkbox"/> Some high school <input type="checkbox"/> Other: <input type="checkbox"/> High school diploma <input type="checkbox"/> GED <input type="checkbox"/> Vocational School <input type="checkbox"/> 1-2 years of college <input type="checkbox"/> 3-4 years of college <input type="checkbox"/> Undergraduate Degree <input type="checkbox"/> Associates Degree <input type="checkbox"/> Certificate							
Street Address				City		State	
Mailing Address (if different from street address)				City		State	
						Zip	
County of Residence							
What type of housing do you have? <input type="checkbox"/> Shelter <input type="checkbox"/> I own my home <input type="checkbox"/> Street/Car <input type="checkbox"/> Rental with subsidy <input type="checkbox"/> Rental without subsidy <input type="checkbox"/> Staying with family <input type="checkbox"/> Staying with friends <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> Other: _____							
Please list your entire household's income from the last 30 days							
Amount		Source		Amount		Source	
\$				\$			
\$				\$			
Does anyone in your household receive any of these non-cash benefits? <input type="checkbox"/> No <input type="checkbox"/> TANF Child Care <input type="checkbox"/> TANF Transportation <input type="checkbox"/> Section 8 <input type="checkbox"/> WIC <input type="checkbox"/> SNAP, Amount \$							
Emergency Contact Name		Relation		Main Phone		2nd Phone	

Client Signature

Staff Signature

Date