

## Client Intake Form

Client ID: _____
Intake _____
Recert _____
(for office use)

What services are you looking for? (circle all that apply) \_\_\_\_\_ Date: \_\_\_\_\_

- |                     |                   |                           |              |                           |
|---------------------|-------------------|---------------------------|--------------|---------------------------|
| Food                | Energy Assistance | Early Childhood Education | Housing      | Senior Services           |
| (SNAPO, Food Shelf) | Crisis Nursery    | Child Care Resources      | Thrift Store | (Senior Nutrition, Chore) |

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  
 Address: \_\_\_\_\_  Homeless City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Text Messages:  Yes  No Email: \_\_\_\_\_  
 Emergency Contact – Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Preferred Method of Contact: \_\_\_\_\_  
 Service(s) Provided: \_\_\_\_\_

**Household Information: (please list all members of the household)**

	Household Member Name(s)	Relationship to HH	Type of Medical Ins.	Birthdate	Primary Language	Gender Identity	Education Level	Primary Race	Hispanic Y/N	Disability Y/N
1.		self								
2.										
3.										
4.										
5.										
6.										

Gender options: Female, Male, Transgender, Other Race options: White, Black/African-American, Asian, American Indian, Pacific Islander, Multi-Racial, Other  
 Education options: Grade completed (7<sup>th</sup>, 8<sup>th</sup>, 9<sup>th</sup>, etc.), HS diploma, GED, Trade school, Some college, Associate degree, Bachelors degree, Masters degree  
 Medical Insurance options: Private, Medicaid, Medicare, Military, State Children's Health Insurance Program, Other public

Are you a veteran? Yes No Anyone else? Yes No Who? \_\_\_\_\_  
Is anyone a migrant worker (someone who lives in another location temporarily for work)? Yes No Who? \_\_\_\_\_  
Are you a registered voter? Yes No Anyone else? Yes No Who? \_\_\_\_\_

Housing Situation: Rent Own Homeless At Risk of Homelessness Other: \_\_\_\_\_

Family Type: Two-Parent Household Single Parent-Female Single Parent-Male Adult(s)-no children Caregiver(s)  
Grandparent(s) and Children Foster Parent(s) Non-Custodial Other: \_\_\_\_\_

Income: Are you employed? Yes No FT PT Anyone else? Yes No Who? \_\_\_\_\_

What is your monthly household income? \$ \_\_\_\_\_ per month

What is the source(s) of your income?

Wages Social Security (RSDI) Veteran Benefits (VA) Tribal Payments  
Worker's Compensation Supplemental Social Security (SSI) Unemployment Insurance Retirement Benefits  
Child Support or Spousal Support Other Unearned Income (Trusts, Gifts, Gambling, Ect.)

**Non-Cash Benefits:** (please check all that you receive)

Food Support/SNAP Head Start Free and reduced breakfast/lunch Energy Assistance WIC  
Section 8 or Public Housing Earned Income Tax Credit (EITC) Childcare Assistance Medicare Medicaid

**Consent and Signature Release**

Please initial each line and sign below

\_\_\_\_\_ I affirm that all data in this application is correct.

\_\_\_\_\_ I have received or reviewed the Privacy Practices Notice and Tennessee Warning before signing.

\_\_\_\_\_ I have received or reviewed instructions on how to file a complaint with the USDA.

\_\_\_\_\_ I release, save, and hold harmless the Scott-Carver-Dakota CAP Agency, Inc., its current or former Board members, employees, officers, directors, attorneys, insurers, and agents (each a "Covered Party") from any and all claims, demands, suits, costs, judgments, or other forms liability, or actual or claimed, including attorneys' fees and punitive damages, arising out of or resulting from any action or omission by any Covered Party in connection with any service provided, and/or program administered, by the Scott-Carver-Dakota CAP Agency, Inc., receipt of assistance through a program administered by Scott-Carver-Dakota CAP Agency, Inc., and/or the use of any products, items or services purchased with the funds provided by a program administered by Scott-Carver-Dakota CAP Agency, Inc.

**Data Privacy Notice/Tennessee Warning**

**Scott Carver Dakota CAP Agency, Inc.**

You have rights under the Minnesota Government Data Practices Act. This Act protects your privacy. We are asking for information so we can: tell you apart from other persons with a similar name and decide how to serve you best.

Generally, you are not required to give us the information. However, without it, we can't report accurate statistics which affects funding. The law allows us to share your information (the number of children, adults, and seniors in your household and the number of pounds of food received) with staff from the Department of Human Services, Hunger Solutions Minnesota, and Second Harvest Heartland and others who may be authorized to view your information to do their jobs.

You also have the right to copies of information we have about you. If you do not understand the information, it may be explained to you. If you do not think the information is accurate or complete, please correct it with the food shelf staff.

I understand that this data privacy notice will expire one (1) year after I have signed it.

Applicant/Participant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Minnesota: The Emergency Food Assistance Program (TEFAP)  
Annual Eligibility Form  
United States Department of Agriculture (USDA)**

CAP Agency

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Number of people in household: \_\_\_\_\_ Children ages 0-17 \_\_\_\_\_ Adults ages 18-64 \_\_\_\_\_ Seniors ages 65+

I am eligible to receive TEFAP commodity food because I am in Minnesota and because my household income is 300% or less of the Federal Poverty Guidelines. I am also eligible if I receive or participate in any the following:

**OPTIONAL: Check the program(s) in which you participate:**

- |   |  |
|---|--|
| <input type="checkbox"/> MFIP – Minnesota Family Investment Program         | <input type="checkbox"/> Child Care Assistance |
| <input type="checkbox"/> GA – General Assistance                            | <input type="checkbox"/> Head Start            |
| <input type="checkbox"/> SNAP – Supplemental Nutritional Assistance Program | <input type="checkbox"/> Section 8             |
| <input type="checkbox"/> NAPS – Nutritional Assistance Program for Seniors  | <input type="checkbox"/> Public Housing        |
| <input type="checkbox"/> WIC – Women, Infants, and Children                 | <input type="checkbox"/> Energy Assistance     |
| <input type="checkbox"/> Weatherization                                     |  |

Income Eligibility: (300% of Federal Poverty Guidelines)			
Family Size	Annual Income	Family Size	Annual Income
One	\$0 - \$43,740	Five	\$90,001 - \$105,420
Two	\$43,741 - \$59,160	Six	\$105,421 - \$120,840
Three	\$59,161 - \$74,580	Seven	\$120,841 - \$136,260
Four	\$74,581 - \$90,000	Eight	\$136,261 - \$151,680
Add \$5140 of allowable income for each additional family member			

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