WWW.STVHOPE.ORG

Today's Date: ___ / ___ / _____

HEAD OF HOUSEHOLD: Please fill out the section below for the head of your household

1 First name

Last name

2 Date of Birth

____ / ____ / _____

3 Race / Ethnicity

- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic
- ☐ Native American
- ☐ Other:

4 Education

- ☐ Some high school
- ☐ High school grad
- ☐ GED
- ☐ Some college
- ☐ College degree
- ☐ Other:

5 Employment

- ☐ Working
- ☐ Not working
- ☐ Unable to work / disabled
- ☐ Retired
- ☐ Other:

6 Sex

- ☐ Male
- ☐ Female
- ☐ Transgender man
- ☐ Transgender woman
- ☐ Other:

7 Phone Number

(_____) - _____ - _____

SSN (optional)

_____ - ____ - _____

8 HOUSEHOLD ADDRESS

☐ **If you are homeless, check this box** and skip to question 9

Address

City / State / Zip / County

Email (optional)

9 What is the total income of <u>all</u> household members (per month)?
(gross income before deductions)

$

10 How many people in your household are... *(write the numbers in the boxes below ↴)*

Under 18 years old

18 to 59 years old

60 and over

11 Does your household receive any of the help listed below? *(mark those that apply)*

- ☐ TANF
- ☐ SNAP (Food Stamps)
- ☐ CHIP
- ☐ SSI
- ☐ Medicaid
- ☐ WIC
- ☐ ***None of the above***

12 Was there an emergency situation that caused you to need food?
If so, please explain below ↴

Sign below if you are applying for assistance from the Galveston County Food Bank ↴

X_____ _____

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...

Continue on the next page

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

Nondiscrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA **Program Discrimination Complaint Form**, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:
1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.
This institution is an equal opportunity provider.

AGENCY DOCUMENTATION – GCFB Eligibility

☐ **Household is ELIGIBLE based on...**	☐ **Household is INELIGIBLE**
☐ Low income ☐ Receipt of TANF/AFDC ☐ Receipt of SNAP (food stamps) ☐ Receipt of SSI ☐ Receipt of Medicaid ☐ Emergency Food Need ↴	☐ Income level over 185% listed on Annual Income Guidelines ☐ it is not an emergency situation and does not meet any other criteria ☐ Other: *clients denied USDA products should be referred to the HFB for review

If "emergency need" please describe below. Clients in this category may be served no more than 6 months unless another emergency can be documented. **Emergency need comments:**

If household is eligible based on criteria above ↴

Certification Period: Start Date: _____ End Date: _____

Agency Staff Initials: _____ Revisit form on: _____

13 **Mark the highest level of education for your entire household**

- ☐ Less than high school grad
- ☐ High school diploma
- ☐ GED
- ☐ Some college
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's or doctoral degree
- ☐ Other (explain below ↴)

14 **List the names of anyone in your household who works (more than 1 hour per week)**

Person's Name	*Hours per week*
_____	_____
_____	_____
_____	_____

Individuals in the household

Please fill out the following information for each additional person in the household *(besides the head of the household)*

15a **First Name** **Last Name**

15b **Date of Birth** MM / DD / YYYY **Age** (in years)

____ / ____ / _____

15c **Sex** Male Female Other

Race Black Hispanic White Other

15d **Person's relation to you**
(e.g. child, spouse, roommate)

SSN (optional)
_____ - _____ - _____

16a **First Name** **Last Name**

16b **Date of Birth** MM / DD / YYYY **Age** (in years)

____ / ____ / _____

16c **Sex** Male Female Other

Race Black Hispanic White Other

16d **Person's relation to you**
(e.g. child, spouse, roommate)

SSN (optional)
_____ - _____ - _____

17a **First Name** **Last Name**

17b **Date of Birth** MM / DD / YYYY **Age** (in years)

____ / ____ / _____

17c **Sex** Male Female Other

Race Black Hispanic White Other

17d **Person's relation to you**
(e.g. child, spouse, roommate)

SSN (optional)
_____ - ____ - _____

18a **First Name** **Last Name**

18b **Date of Birth** MM / DD / YYYY **Age** (in years)

____ / ____ / _____

18c **Sex** Male Female Other

Race Black Hispanic White Other

18d **Person's relation to you**
(e.g. child, spouse, roommate)

SSN (optional)
_____ - ____ - _____

19a **First Name** **Last Name**

19b **Date of Birth** MM / DD / YYYY **Age** (in years)

____ / ____ / _____

19c **Sex** Male Female Other

Race Black Hispanic White Other

19d **Person's relation to you**
(e.g. child, spouse, roommate)

SSN (optional)
_____ - ____ - _____

Charity Tracker - Release of Information (ROI)

The **Mainland Communities Services Assistance Network**, *hereinafter referred to as "CharityTracker"*, is a shared, computerized record keeping system that captures information about people experiencing need for emergency services, including but not limited to assistance with utility bills, medications, rent/mortgage payments, etc. United Way Galveston County Mainland (*Administrating Agency*) administers CharityTracker on behalf of participating agencies of the CharityTracker Assistance Network, including St. Vincent's House (*Participating Agency*).
I understand that all information gathered about me is personal and private and that I do not have to participate in CharityTracker. I have had an opportunity to ask questions about CharityTracker and to review the basic identifying information, which is authorized by this release for the CharityTracker Assistance Network Participating Agencies to share. I also understand that information about nonconfidential services provided to me by CharityTracker participating agencies may be shared with other CharityTracker Participating Agencies. This Release of Information will remain in effect for 3 years from the date noted under my signature at the bottom of this page unless I make a formal request to this Organization that I no longer wish to participate in CharityTracker.

I authorize St. Vincent's House, as a CharityTracker Participating Agency, to share my basic, identifying and nonconfidential service transactions/information with other CharityTracker Participating Agencies. I authorize the use of a copy of this original to serve as an original for the purposes stated above. I further authorize St. Vincent's House (Participating Agency), as a CharityTracker Participating Agency, to share my dependent's basic, identifying and non-confidential service transactions/information with other CharityTracker participating agencies.

X _____ _____

Client Authorizing Signature **Date**

_____ _____

Agency Representative Signature Date

Consent to seek donor assistance

I give my consent to St. Vincent's House to circulate my name for the purpose of seeking donor assistance on my behalf.

X _____ _____

Signature **Date**

Continue on the next page

We use this survey to recommend potential other services we could offer, and **your responses will <u>not</u> keep you from receiving our services.**

For each row in the table below, please circle the box that best describes your **household's** current situation. Thank you!

	1	2	3	4	5
Food	No food or relies on free/low cost food	Receives Food Stamps / SNAP	Can meet basic needs with **occasional assistance**	Can meet basic needs **without assistance**	Able to purchase any food desired Has healthy foods
Income	No income Not working	Not enough income to meet **basic needs**	Can meet basic needs with **occasional assistance**	Can meet basic needs **without assistance**	Making enough money to *build savings*
Housing	Homeless Has eviction notice	**Temporary** housing Rent / mortgage is **over 1/3 of income**	Stable housing, but **not safe**	Stable, safe housing **Government housing**	Safe, stable, and unsubsidized housing
Medical	No medical coverage *__AND__* need medical care soon	No medical coverage *__OR__* difficulty getting care	Some (but *not everyone*) in the household **has medical insurance**	Everyone in house has insurance, but **coverage not good enough**	Everyone in house has insurance *and* spends <10% of income care
Legal (optional)	Current outstanding tickets or warrants	**Current charges** or pending trial	**On probation/parole** (in good standing)	**No new charges** in past year	Box #4 ***AND*** no history of felony
Employment (if able to work)	No job or work in past week	Employed **part-time**, but not enough pay	Working >32 hours a week but **not enough pay** **No benefits**	Works full time with **enough pay to meet basic needs**	*Permanent* full-time job (for past 3 months)