ALLEGHENY COUNTY DEPARTMENT OF HUMAN SERVICES
COMMUNITY SERVICES BLOCK GRANT PROGRAM
INTAKE SERVICE APPLICATION

1.CONTRACTOR NAME _____ 2.SUB-CONTRACT CODE: ☐☐☐☐

3.SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐ 4.DATE OF BIRTH ☐☐/☐☐/☐☐

5.NAME _____
FIRST MI LAST

6.STREET _____

MUNICIPALITY _____ ZIP ☐☐☐☐☐ COUNTY DISTRICT ☐☐

PHONE (☐☐☐)☐☐☐-☐☐☐☐ 7.☐ RECEIVES FOOD STAMPS

8. EDUCATION
☐ 0-8 ☐ 9-12/NON-GRAD
☐ HS GRAD / GED
☐ 12+ SOME POST-SECONDARY
☐ 2 OR 4 YEARS COLLEGE GRAD

9. ETHNICITY/RACE
I. ETHNICITY (check a. or b.)
☐ a. HISPANIC OR LATINO
☐ b. NOT HISPANIC OR LATINO

II. RACE (check one box)
☐ WHITE
☐ BLACK OR AFRICAN AMERICAN
☐ AMERICAN INDIAN OR ALASKA NATIVE
☐ ASIAN
☐ NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER
☐ OTHER
☐ MULTI-RACE (2 or more of above)

10. GENDER
☐ FEMALE ☐ MALE

11. CHARACTERISTICS
(CHECK ALL THAT APPLY)
☐ HAS HEALTH INSURANCE *(INCLUDING MA & MEDICARE)*
☐ HAS NO HEALTH INSURANCE
☐ PROVIDED CHIP INFORMATION
☐ IS DISABLED
☐ IS NOT DISABLED
☐ EX-OFFENDER
☐ MENTAL HEALTH
☐ MENTAL RETARDATION
☐ DRUG & ALCOHOL

11. CHARACTERISTICS CONTINUED
☐ VETERAN ☐ STUDENT
☐ HEAD START PARENT
☐ DISPLACED HOMEMAKER
☐ DRIVER'S LICENSE

12. HOUSING STATUS
☐ OWN ☐ HOMELESS
☐ RENT ☐ OTHER

13. HOUSING TYPE
☐ APARTMENT ☐ HOUSE
☐ OTHER

14. FAMILY TYPE
☐ 1 PARENT / FEMALE
☐ 1 PARENT / MALE
☐ 2 PARENT
☐ 2 ADULTS NO CHILDREN
☐ SINGLE ☐ OTHER

15. MARITAL STATUS
☐ SINGLE ☐ MARRIED
☐ DIVORCED ☐ SEPARATED
☐ WIDOWED ☐ OTHER

16. FAMILY SIZE _____

17. ELIGIBILITY
☐ ACCESS (Medical Assistance) CARD
Fill out EVS Verification of ACCESS Card on reverse side of this form AND check sources of income in 18 A,B,C, and D
☐ ELIGIBLE ☐ INELIGIBLE

18. FAMILY INCOME (LAST 30 DAYS)
A. ☐ NONE
B. ☐ WAGES EARNED (LAST 30 DAYS)
$ _____ *(WAGE AMT.)*

C. OTHER APPLICABLE SOURCES (LAST 30 DAYS)

AMOUNT	SOURCE
☐ $_____	SOCIAL SECURITY
☐ $ _____	UNEMPLOYMENT
☐ $ _____	WORKERS COMP
☐ $ _____	CHILD SUPPORT
☐ $ _____	PENSION
☐ $ _____	OTHER CASH

D. NON-APPLICABLE SOURCES
(CHECK ALL THAT APPLY)
☐ TANF ☐ SSI
☐ GENERAL ASSISTANCE
☐ SOCIAL SEC. DISABILITY (SSD)
☐ TRAINING PROGRAM STIPEND
☐ FOSTER CHILD SUPPORT

19. ELIGIBILITY DETERMINATION
APPLICABLE INCOME, LAST 30 DAYS (ADD TOGETHER B AND C, WAGES AND OTHER APPLICABLE SOURCES)
$ _____

ANNUALIZED INCOME (MULTIPLY AMOUNT IN NUMBER 19 BY 12): $ _____ ☐ ELIGIBLE ☐ INELIGIBLE
(COMPARE WITH FAMILY SIZE ON 125% OF FEDERAL POVERTY GUIDELINE CHART)

20.FAMILY MEMBER INFORMATION (Use reverse side of this form for additional family members)

NAME	RELATION	SOCIAL SECURITY #	DATE OF BIRTH	GENDER
				M F
				M F
				M F
				M F

I certify that the above information is true to the best of my knowledge. I allow release of this information for the expressed purpose of determining program eligibility. I understand that this information will be held in strict confidence.

Applicant signature _____ Date ☐☐/☐☐/☐☐
(parent or guardian if applicant is under 18)

Interviewer's signature _____ REVISED 2/7/12

17. ELIGIBILITY ACCESS CARD VERIFICATION USING ELECTRONIC VERIFICATION SYSTEM (EVS)

A. Document ACCESS Card Numbers

ACCESS Card Recipient Number _____

Card Issue Number _____

Date _____

B. Follow directions for the EVS and enter the following chart

1. Date verified the ACCESS card using EVS
2. EVS Responses of Birth date (BD), Gender (G) and MA Codes (Health Care Benefits (HCB), Category (C), and Program Status (PS)

Month:		Day:		Year:	
Birth date:			Gender	M ☐ F☐	
HCB:		Cat:		PS:	
ELIGIBLE YES ☐ NO ☐					

20. FAMILY MEMBER INFORMATION (continued)

NAME	RELATION	SOCIAL SECURITY #	DATE F BIRTH	GENDER
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F