Client ID #

Program Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INTAKE FORM

**SS#: Last Name: First Name:**

**DOB: Address:**

**City: Zip: County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone #:**  **Message Phone #:**  **Whose Phone:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Gender:**  Female  Male |  | **Disabled:**  Yes  No | |  | | --- | | **Ethnicity:**  **H**ispanic, Latino or Spanish Orgin  **N**ot **H**ispanic, Latino or Spanish Orgin | | **Race:**  **W**hite  **B**lack/African American  **A**sian  **N**ative **H**awaiian/**P**acific **I**slander  **N**ative **A**merican/Native Alaskan  **O**ther  **A**sian and **W**hite  **B**lack/African Ameriacan and **W**hite  Other **M**ulti-**R**ace (any 2 or more above) | | |
|  |  |  |  |  |  | |
| **Agency Site:** | | | | |  | **Client E-mail:** |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Education:**  A. 0-8  B. 9-12 (Non-Grad)  C. HS Grad/GED  D. 12+  E. 2-4 yr. Grad College |  | **Food**  **Stamps:**  Yes  No |  | **Health Insurance:**  A. Medicaid  D. Self-Ins.  B. Medicare  E. None  C. Private  F. Unknown |  | **Farmer:**  A. Farmer  B. Migrant  C. Seasonal |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Veteran:**  Yes  No |  | **# In**  **HH** |  | **Family Type:**  F. Single Par/Female  Single  M. Single Par/Male  Couple  Two Parent  Other |  | **Housing:**  Own  Rent  Homeless  Other |  | **Income Eligibility Period:**  A. Weekly  D. Annually  B. Bi-Weekly  E. 13 Weeks  C. Monthly  F. 3 Months  G. 6 Months |

|  |  |
| --- | --- |
| **Source of Income:**  A. Employment  C. Social Security  E. GA  G. Pension  I. Other  B. Unemployment  D. TANF  F. SSI/SSD  H. No Income  J. Zero Income  K. Refused – Only used for programs that do NOT require income verification | **Income Amount:** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Other Household Members Use codes from above ONLY for information listed below | | | | | | |
| SS# |  |  |  |  |  |  |
| Last Name |  |  |  |  |  |  |
| First Name |  |  |  |  |  |  |
| **Date of Birth** |  |  |  |  |  |  |
| Male/Female(M, F) |  |  |  |  |  |  |
| **Disabled**  (Y, N) |  |  |  |  |  |  |
| **Ethnicty**  (H, NH) |  |  |  |  |  |  |
| **Race** (W, B, A, NHPI, NA, W, O, AW, BW, MR) |  |  |  |  |  |  |
| **Education**  (A, B, C, D, E) |  |  |  |  |  |  |
| **Veteran**  (Y, N) |  |  |  |  |  |  |
| **Health Insurance**  (A, B, C, D,E, F) |  |  |  |  |  |  |
| **Income Period:**  (A, B, C, D, E, F, G) |  |  |  |  |  |  |
| **Source** (A, B, C, D, E, F, G, H, I,J,K) |  |  |  |  |  |  |
| **Relation to Applicant** |  |  |  |  |  |  |
| **Income Amount** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MYCAP USE ONLY:** |  |  |  |  |  |  |  |  |  |  |  |  |  | **Initials** | **Date** |
| **FPG/AMI** |  |  |  |  |  |  |  |  |  |  |  |  | **Intake:** |  |  |
| **Months Paid:** |  |  |  |  |  |  |  |  |  |  |  |  | **Data Entry** |  |  |

**Assistance Request Related to COVID-19 Pandemic**

A State of Emergency has been declared in the United States of America and the State of Ohio due to the COVID-19 global pandemic. There is no person in the country that is not affected by COVID-19. I, like thousands of others across the state, am requesting assistance to my pay my rent, mortgage and/or utility payment(s) in part or in full. I, and/or other residents in my home, have experienced the following circumstances due to the Global Pandemic and State of Emergency it has caused:

❏ Loss of Work / Decrease in Available Hours at Work

❏ Forced Work Closure

❏ Inability to Access or Get to Work

❏ Unpaid wages or Other Unpaid Compensation Ordinarily Received

❏ Increase in Childcare Costs

❏ Forced to Take Off Work due to School Closure or Childcare Change

❏ Self Quarantined at Home under Government or Medical Recommendation

❏ Stay at Home or Shelter in Place Order by any level of Government Authority

❏ Forced to Take Off Work to Care for a Family Member

❏ Personal or Family Experiencing Illness, Disability, or Mental Health Issues

❏ Lack of Access or Delayed Access to Healthcare

❏ Experience of Food Insecurity, Shortages, or Delayed Benefits

❏ Increase in Family Expenses due to Pandemic or Emergency Preparedness

❏ Unemployment Insurance Unavailable, Insufficient, or Delayed

❏ Emergency Assistance Unavailable, Insufficient, or Delayed

❏ Loss of Social, Financial, or Health Safety Net

❏ Fear and Concern of Future Economic and Health Insecurity and Instability

❏ If I Pay for Rent Now, I Will Not be Able to Meet My or My Family’s Basic Needs

❏ OTHER:

***I certify that this statement is true and correct to the best of my knowledge, and I authorize the release of any or all information necessary for verification purposes***.

Applicant Signature: Date:

MYCAP Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_