

Intake Date:			GROSS	1.			2.	3.	4.	5.	6.	7.	
Status	First Name	MI	Last Name	Income	Inc. Source	Date of Birth	M/F	Race	Eth	Char	Lang	Edu	Rel
Head of House						/ /							
						/ /							
						/ /							
						/ /							
						/ /							
			TOTAL GROSS INCOME										

Mailing Address	1. Income Source: SS-Social Security, SSI-Supplemental Security Income, SSDI-Social Security Disability Income, PEN-Pension/Retirement, Wages-Wages, INT-Interest Income, OTHER _____ 2. Race: A-Asian, AA-Black/African American, C-Caucasian/White, P-Pacific Islander, M-Bi-racial/Multi-racial, N-Native American, U-Unknown 3. Ethnicity: U-Unknown, H-Hispanic or Latin, N-Not Hispanic 4. Characteristics: A-Applicant, D-Disabled/Handicapped, S-SER Eligible, M-Medicare/Medicaid, H-Homebound, N-No Health Insurance, U-Utility Shutoff Notice 5. Language: E-English, S-Spanish 6. Education: AH-Adult High School Graduate, AA-Associates Degree, BS-Bachelor's Degree, AG-Adult General Ed Diploma, P-Preschool/Kind, C1-Child Grade 1-6, Y7-Youth Grade 7-8, Y8-Youth Grade 9-12 7. Relationship: I-Individual, SP-Spouse, P-Partner, M-Mother, F-Father, S-Son, D-Daughter, SC-Stepchild, GP-Grandparent, GC-Grandchild
City/State/Zip	
Physical Address-if different	
Work Phone	
Cell Phone	
Home Phone	
County	

Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Partner <input type="checkbox"/> Widowed Military Status: <input type="checkbox"/> Active Duty <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Unknown WHO _____ Health Insurance <input type="checkbox"/> MC <input type="checkbox"/> MCaid <input type="checkbox"/> Private <input type="checkbox"/> None <input type="checkbox"/> Unknown WHO _____	Family Type: <input type="checkbox"/> Married (living w/children) <input type="checkbox"/> Married (no children) <input type="checkbox"/> Multiple Adults (living w/children) <input type="checkbox"/> Multiple Adults (no children) <input type="checkbox"/> Foster Parent (w/foster child/children) <input type="checkbox"/> Grandparent <input type="checkbox"/> Single parent-female (living w/children) <input type="checkbox"/> Single parent-male (living w/children) <input type="checkbox"/> Single person (living alone)	Living Arrangements: <input type="checkbox"/> Own <input type="checkbox"/> Rent-Unsubsidized <input type="checkbox"/> Rent-subsidized (HUD, Section 8) <input type="checkbox"/> Living w/friends or family <input type="checkbox"/> Homeless <input type="checkbox"/> Homeless by choice <input type="checkbox"/> Transitional/shelter <div style="border: 1px solid black; padding: 5px; width: fit-content;"> FacsPro _____ Scan _____ Access _____ DATA _____ </div>
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*Certification Statement: I certify that the information I have provided is complete and correct to the best of my knowledge and is made in good faith. I further give my consent to MDSCAA personnel to verify eligibility and provision of services. I am aware that this application may be forwarded to other departments of MDSCAA.

*I give the Menominee-Delta-Schoolcraft Community Action Agency consent to release, obtain and share all pertinent identifying and non-confidential social, medical and other information about myself and information I have provided about additional family members that will allow me and my family to benefit from services offered. In granting such permission, I understand that such information will remain confidential and that such information will only be used for my benefit or to benefit other members of my family. Only authorized personnel will share client information needed for service delivery, or to track demographic trends, service patterns and the client outcomes achieved. I release MDSCAA and its staff from any legal liability for disclosing or acquiring information that I have permitted by signing this form. Unless I make a formal request to MDSCAA that I no longer want to participate in the services offered, this release will remain in force for TWO years from today. MDSCAA, its agent, partners and funding sources do not discriminate on the basis of race, color, sex, age, religion, national origin, disability, or marital status.

*This application is being completed in connection with the receipt of Federal assistance. Program officials may verify information on this form. I am aware that deliberate misrepresentation may subject me to prosecution under applicable State and federal statutes. Furthermore, I am aware that the information provided may be shared with other organizations to detect and prevent dual participation. I have been advised of my rights and obligations under the program. I certify that the information I have provided for my eligibility determination is correct to the best of my knowledge.

*I authorize the release of information provided on this application form to other organizations administering assistance programs for the use in determining my eligibility for participation in other public assistance programs and for program outreach purposes. **Yes** **No**

*MDS CAA prohibits discrimination against its customers, employees, and applicants for employment on the basis of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the AGENCY (Not all prohibited bases will apply to all programs and/or employment activities.).

*Individuals who are deaf, hard of hearing or have speech disabilities may contact THE AGENCY through the Federal Relay Service at (800)877-8339; MDSCAA is an equal opportunity provider and employer.

Applicant Signature: _____ **Date:** _____

Application reviewed by:

MDSCAA Staff Signature: _____ Date: _____