It is ADFAC's policy not to discriminate on the basis of the following conditions: race, color, national origin, sexual orientation, religion, sex, age, handicap, or disability.

ADFAC CLIENT INTAKE

PLEASE PRINT

_____
Current Date

_____
Social Security Number

_____ _____ _____ _____ _____
Last Name **First Name** **Middle Name** **Preferred Name** **Birth date**

_____ _____ _____ _____
Current Street Address **Phone Number** **Alternate phone** **Email Address**

_____
City State ZIP Code

How Long at Current Address? _____ **Years Months** **How Long in Oak Ridge?** _____

# of People at This Address _____

Gender Identity: __ **Male** __ **Female** __ **Third Gender**

_____
Previous Street Address

How Long there? _____/_____ **Years Months**

_____
City State ZIP Code

Marital Status:

__ **Married** __ **Divorced**
__ **Single** __ **Widowed**
__ **Separated** __ **Partnership**

Are You Head of Household ____

Are You Working? _____

Are You In School? _____

Income Level:

Extremely Low Income __
Very Low Income __
Low-Moderate Income __
N/A __

Housing Status:

__ **UNS**
__ **SHELT**
__ **OVC**
__ **HPA**
__ **Other**

Race:

__ **White Non-Hispanic**
__ **Black Non-Hispanic**
__ **Hispanic/Latino(a)**
__ **Asian or Pacific Islander**
__ **Native American**
__ **Alaskan Native**
__ **Multi-racial**
__ **Middle Eastern**

Please Enter Information for Spouse or Companion Who Is Living with You at the SAME ADDRESS:

_____ _____ _____ _____ _____
Social Security Number **Last Name** **First Name** **Middle Name** **Birthdate**

Sex: _____**Male** _____ **Female** _____ **Third Gender**

Race of Spouse/Companion:

__ **White Non-Hispanic**
__ **Black Non-Hispanic**
__ **Hispanic/Latino(a)**
__ **Asian or Pacific Islander**
__ **Native American**
__ **Alaskan Native**
__ **Multi-racial**
__ **Middle Eastern**

Is Spouse/Companion Head of Household? ____

Is Spouse/Companion Working? _____

Spouse/Companion Employer _____

Is Spouse/Companion in School? _____

List ONLY Children Living With You:
(18 years or younger)

Social Security Number	Last Name	First Name	Sex	Date of Birth	Age

Comments: _____

List All Other Adults (Besides Spouse/Companion) Living in This Household, Including Children Over 18

Soc. Security #	Last Name	First Name	Middle Initial	Sex	Date of Birth	Relationship to Client

AUTHORIZATION TO RELEASE INFORMATION

I understand that ADFAC maintains a clearinghouse database that collects information about persons seeking assistance and can share such information with other social service agencies, utility companies, rental and mortgage agencies, and churches. I authorize ADFAC to share information about my household with these agencies and churches.

I also understand that in order to make an informed decision about assisting my household, ADFAC may seek information about my household from landlords, employers, mental health professionals, police, and other agencies or groups that may have had contact with me or any member of my household in the past or may do so in the future. I authorize the above mentioned to release any information requested by ADFAC. I agree to waive any liability ADFAC or its agents, staff, or other representatives, the above agencies or individuals might have for the release of such information.

I agree to treat all members of ADFAC with dignity and respect, speaking in a calm voice and not using abusive or profane language. In agreeing to the above, I understand that not fulfilling this agreement may disqualify me from receiving ADFAC assistance.

I certify that all information provided by me in this document is accurate and true to the best of my knowledge. I understand that omission or falsification of any information will result in denial of services for a minimum of one year.

Client Signature _____ Date _____

REQUESTED RESOURCES:

Child Care	Clothing closets/Thrift Store
Food Pantries	Household Goods
Medical/Dental Resources	Phone or Cable/Internet
Education/Employment Opportunities	Housing/Utilities
Transportation	Weatherization
School Supplies	Pet Assistance
Disability(ies)	Legal Assistance/ Renter's Rights
Counseling/ Mental Health/Trauma	Substance Abuse/Addiction
Stop Smoking	Veteran Assistance

MONTHLY HOUSEHOLD INCOME

Your Gross Monthly Income $_____
Your Employer:

_____
How long there _____
Hrs/Wk_____
Hourly Wage $_____

Spouse/Partner Monthly Income $_____
Spouse/Partner Employer:

_____
How long there_____
Hrs/Wk_____
Hourly Wage $ _____
Other Gross Monthly Income $_____
(from employment of other $_____
household members) $_____

Unemployment _____ $_____
Whose

Worker's Comp _____ $_____
Whose

Pension or _____ $_____
Retirement Whose

Social Security Income
SSI (whose)_____ $_____
SSI (whose)_____ $_____

Total Income $_____

ADDITIONAL HOUSEHOLD BENEFITS

$_____ SNAP
$_____ HUD
$_____ Utility Allowance (HUD)
$_____ WIC
$_____ Families First/TANF
$_____ Child Support Received
$_____ Other
$_____ Total Benefits

MONTHLY HOUSEHOLD EXPENSES

Rent/Mortgage $_____
Value of home if owned $_____
Utilities:
Electricity $_____
Gas Heat $_____
Water/Sewer $_____
Telephone (home/cell): $_____
Car Payment $_____
Car Insurance $_____
Gas/Maintenance $_____
Transportation $_____
Credit Card Payments $_____
Rent-To-Own Payments $_____
Pawn Shop Payments $_____
Check Advance Payments $_____
Probation/Court Cost Payments $_____
Other Loans: _____ $_____
_____ $_____
Paycheck Garnishments $_____
Child Support Paid Out $_____
Medical/Dental Bills $_____
Medications (not covered by Insurance) $_____
Health/Life Insurance $_____
Real Estate Insurance $_____
Food (not bought with SNAP benefits) $_____
Tobacco/Alcohol $_____
Diapers/Hygiene items $_____
Household Supplies $_____
Pet Expenses $_____
Cable/Satellite/Dish/Internet $_____
Child Care $_____
Laundromat $_____
Child Support Paid Out $_____
Property Taxes $_____
Other: _____ $_____
_____ $_____

TOTAL EXPENSES $_____

Total of income minus expenses $_____

The goal of the Household Assistance Program is to help you achieve or maintain self-sufficiency.

What challenges are you facing regarding financial stability?

What strengths/resources do you have that can help you with these challenges?

If you are approved for assistance today, please know that it will be 12 months before you may receive assistance again. How do you plan to pay your bills moving forward?

CLIENT ACTION SHEET **Last Name, First Name** _____

Social Security Number_____

Date_____ **Action** _____ **Funding Source** _____

Check # _____ **Amount** _____ **Time: SW** ____ **CW** ___ **Vol** ____**AD** ___

Comments:_____*Initials*_____ *Date* _____ ☐

Date_____ **Action** _____ **Funding Source** _____

Check # _____ **Amount** _____ **Time: SW** ____ **CW** ____**Vol** ____ **AD** ___

Comments:_____ *Initials*_____ *Date* _____ ☐

Date_____ **Action** _____ **Funding Source** _____

Check #_____ **Amount** _____ **Time: SW** ____ **CW** ____**Vol** ____**AD** ___

Comments:_____ *Initials*_____ *Date* _____ ☐

Date_____ **Action** _____ **Funding Source** _____

Check #_____ **Amount** _____ **Time: SW** ____ **CW** ____**Vol** ____**AD** ___

Comments:_____ *Initials*_____ *Date* _____ ☐

Date_____ **Action** _____ **Funding Source** _____

Check #_____ **Amount** _____ **Time: SW** ____ **CW** ____ **Vol**____**AD** __

Comments:_____ *Initials*_____ *Date* _____ ☐

Date_____ **Action** _____ **Funding Source** _____

Check #_____ **Amount** _____ **Time: SW** ____ **CW** ____ **Vol**____**AD** __

Comments:_____ *Initials*_____ *Date* _____ ☐