

**INTERFAITH FOOD PANTRY  
GROCERY ASSISTANCE PROGRAM REFERRAL FORM**

AGENCY \_\_\_\_\_ ADDRESS \_\_\_\_\_

CASE MANAGER \_\_\_\_\_ PHONE \_\_\_\_\_ EXT \_\_\_\_\_ E-MAIL: \_\_\_\_\_ DATE \_\_\_\_\_

[ ] I hereby verify that the information on this form is accurate as written \_\_\_\_\_ If you sign here the client will not need to bring any information other than this form to the interview. Case manager signature

[ ] I cannot verify that the information on this form is accurate as written. In this case, please ask client to bring proof of income and address for each household member listed. In addition, they will need to bring a letter from a school or agency showing the listed children are residing with them.

**APPLICATION FOR FOOD ASSISTANCE**

CLIENT NAME \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
LAST FIRST SS # (IF ANY) AGE DOB OCCUPATION

CLIENT ADDRESS \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
STREET APT/FL/PO TOWN ZIP PHONE E-MAIL COUNTRY OF BIRTH

RACE \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ NATIVE LANGUAGE \_\_\_\_\_ SPECIAL FOOD NEEDS (DIABETIC, ETC.) \_\_\_\_\_

**CONSENT: APPLICANTS MUST SIGN HERE** I consent to the exchange of information between THE above named agency and IFP regarding my request for services. SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**OTHER MEMBERS**

**PLEASE LIST ONLY OTHER MEMBERS OF APPLICANTS IMMEDIATE FAMILY LIVING AT SAME ADDRESS WHO ARE APPLYING FOR FOOD**

	<u>FIRST</u>	<u>MI</u>	<u>LAST</u>	<u>RELATIONSHIP</u>	<u>AGE</u>	<u>DOB</u>	<u>OCCUPATION</u>
1.	_____	_____	_____	_____	_____	____/____/____	_____
2.	_____	_____	_____	_____	_____	____/____/____	_____
3.	_____	_____	_____	_____	_____	____/____/____	_____
4.	_____	_____	_____	_____	_____	____/____/____	_____
5.	_____	_____	_____	_____	_____	____/____/____	_____
6.	_____	_____	_____	_____	_____	____/____/____	_____
7.	_____	_____	_____	_____	_____	____/____/____	_____

**TOTAL HOUSEHOLD GROSS MONTHLY INCOME - MUST INCLUDE INFO ON ALL LISTED ABOVE**

	Salary	Unem- ployment	Social Security	SSI	SSD/Dis.	Pension	Child Supp/ Alimony	TANF [ ] GA [ ]	Food Stamps	Medi- caid	Other	Explain other income
Applicant										Y / N		
1.										Y / N		
2.										Y / N		
3.										Y / N		
4.										Y / N		
5.										Y / N		
6.										Y / N		
7.										Y / N		
<b>TOTAL</b>										Y / N		

**PLEASE ANSWER ALL THE FOLLOWING QUESTIONS**

Do you rent apt. [ ] rent room [ ] own home [ ] live in a shelter [ ] Section 8 ( ) Public Housing ( ) other [ ] \_\_\_\_\_

What caused you to need food assistance? recently lost job [ ] had work hours reduced [ ] no recent change but income does not cover expenses [ ] became disabled/seriously ill [ ] other [ ] please explain (If you have any unusual expenses or circumstances that you would like to tell us about please do so here) \_\_\_\_\_

Are you in danger of losing your housing? No [ ] Yes [ ] If yes, why? \_\_\_\_\_

How did you hear about the IFP? Newspaper [ ] Internet [ ] Friend/Family [ ] Current client [ ] Agency [ ] \_\_\_\_\_

Church/Temple/Mosque attended (if any – information will not be shared) \_\_\_\_\_ Town \_\_\_\_\_

### MONTHLY EXPENSES

Please answer all questions - put none or "0" where appropriate.

Rent/Mortgage you pay yourself \$/Month \_\_\_\_\_  
Electric \$/Month \_\_\_\_\_  
Gas/Oil \$/Month \_\_\_\_\_  
Medical insurance \$/Month \_\_\_\_\_  
Other medical expenses \$/Month \_\_\_\_\_  
Car insurance \$/Month \_\_\_\_\_  
Car payment \$/Month \_\_\_\_\_

Childcare \$/Month \_\_\_\_\_  
Telephone \$/Month \_\_\_\_\_

Other – List each and explain \$ \_\_\_\_\_  
\$ \_\_\_\_\_

OTHER INFORMATION	
Do you get rental assistance? Y N From? _____	How much? _____
Do you get HEA assistance?(Heat)	Y N
Do you get USF assistance? (Gas bill-electrical bill or both)	Y N
Do you get Cooling assistance? (Medical Air condition)	Y N

### IN CASE OF EMERGENCY

Primary Contact \_\_\_\_\_  
NAME RELATIONSHIP PHONE #

Secondary Contact \_\_\_\_\_  
NAME RELATIONSHIP PHONE #

### RELEASE FORM

I certify that all information I provided is true. I understand that I am authorizing the IFP staff to receive information from any agency listed on this form to verify my income and need. I further authorize them to release any information necessary to help them secure additional assistance for me or my family.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_ Interviewer \_\_\_\_\_ Agency \_\_\_\_\_

Referral Counselors comments: \_\_\_\_\_

### IFP STAFF USE ONLY

Reviewer \_\_\_\_\_ Date \_\_\_\_\_ Status eligible [ ] pending [ ] ineligible [ ] Reapplication [ ] Updated app [ ]

If not eligible why? POI [ ] POA [ ] BC [ ] +inc [ ] not MC [ ] other \_\_\_\_\_

PU day assigned 1<sup>st</sup> Tu AM [ ] 1<sup>st</sup> Wed AM [ ] 1<sup>st</sup> Wed Eve [ ] 1<sup>st</sup> Th AM [ ] 1<sup>st</sup> Th PM [ ] 1<sup>st</sup> Sat [ ]  
2<sup>nd</sup> Tu AM [ ] 2<sup>nd</sup> Wed AM [ ] 2<sup>nd</sup> Wed Eve [ ] 2<sup>nd</sup> Th AM [ ] 2<sup>nd</sup> Th PM [ ] 2<sup>nd</sup> Sat [ ]  
3<sup>rd</sup> Tu AM [ ] 3<sup>rd</sup> Wed AM [ ] 3<sup>rd</sup> Wed Eve [ ] 3<sup>rd</sup> Th AM [ ] 3<sup>rd</sup> Th PM [ ] 3<sup>rd</sup> Sat [ ]  
4<sup>th</sup> Tu AM [ ] 4<sup>th</sup> Wed AM [ ] 4<sup>th</sup> Wed Eve [ ] 4<sup>th</sup> Th AM [ ] 4<sup>th</sup> Th PM [ ] 4<sup>th</sup> Sat [ ]

<b>HOME DELIVERY</b> [ ]
Disable [ ] Elderly [ ]
Ill [ ] No transportation [ ]
Other [ ] Mental Health [ ]

Comments: \_\_\_\_\_