



GROCERY ASSISTANCE PROGRAM REFERRAL FORM

AGENCY _____ ADDRESS _____ DATE ____/____/____

CASE WORKER _____ PHONE _____ - _____ - _____ EXT _____ E-MAIL: _____

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 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 _____ LANGUAGE(S) SPOKEN _____

RACE _____ SEX _____ MARITAL STATUS _____ SPECIAL FOOD NEEDS (DIABETIC, ETC.) _____

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. | _____ | _____ | _____ | _____ | _____ | ____/____/____ | _____ |

QUALIFYING REASONS MUST SELECT ONE- [V] CHECK ALL THAT APPLY FOR EACH MEMBER OF HOUSEHOLD)

| | TANF | SNAP | SSI * | WIC | Medicaid | Low Income (185% of PL) | Disaster (Other – divorce, domestic violence, unusual expense, loss of employment, etc. Please explain.) |
|----------------|------|------|-------|-----|----------|-------------------------|--|
| Main Applicant | | | | | | | |
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |
| 6. | | | | | | | |

Main Source of Income: Salary Unemployment Social Security SSI SD/DIS Child Support Alimony Pension

Family/Friends Savings TANF GA Other None

*(Supplemental Social Security) NOT Social Security

OTHER INFORMATION

(If you have any unusual expenses or circumstances that you would like to tell us about please do so here)

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

Monthly Housing Expense \$ _____ Are you in danger of losing your housing? No [] Yes []

If yes, why? _____

Do you receive rental assistance? [] Y [] N From ? _____ Amount \$ _____

Do you receive HEA assistance? (Heat) [] Y [] N Do you receive USF assistance? (Gas bill-electrical bill or both) [] Y [] N

Do you receive Cooling assistance (Medical Air Conditioning) [] Y [] N

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 _____

IN CASE OF EMERGENCY PLEASE CONTACT

Primary Contact _____
NAME RELATIONSHIP PHONE #

Secondary Contact _____
NAME RELATIONSHIP PHONE #

CONSENT AND RELEASE FORM

I certify that all information I provided is true and accurate. I consent to the exchange of information between the referring agency and IFP regarding my request for services. I authorize the IFP to verify the information provided and release information at my request to secure additional assistance for me or my family members.

SIGNATURE: _____ DATE: ____/____/____

Interviewer _____ Agency _____

Referral Counselors comments: (Please provide an explanation of client’s current situation)

To set an appointment call: Case Worker: _____ or Client: _____

Please Fax this form to 973-998-5086