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*:**

_____/_____/_____/_____
ID # (IFPN Staff Only)

GUEST NAME_____ _____ _____ _____/_____/_____ _____ _____
Last First AGE DOB OCCUPATION LANGUAGE

GUEST ADDRESS _____ _____ _____ _____
STREET APT/FL/PO TOWN ZIP CODE

_____-_____-_____ _____ _____
PHONE E-MAIL COUNTRY OF BIRTH

RACE_____ SEX____ MARITAL STATUS _____ SPECIAL FOOD NEEDS (DIABETIC, ETC.) _____

Have you or any member of your household listed on your application served or is serving in the U.S. Armed Forces?**Yes: [ ] No: [ ]**

OTHER MEMBERS

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

	FIRST	MI	LAST	RELATIONSHIP	AGE	DOB	OCCUPATION
1.							
2.							
3.							
4.							
5.							
6.							

QUALIFYING REASONS MUST SELECT ONE- [√] 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.								

Please Check Main Source of Income

[ ] Salary: **[ ] Unemployment:** **[ ] Social Security:** **[ ] SSI:**

[ ] SSD/DIS: **[ ] Child Support:** **[ ] Alimony:** **[ ] Pension:**

[ ] Family/Friends: **[ ] Savings:** **[ ] TANF:** **[ ] GA:**

[ ] SNAP (Food Stamps): **[ ] *(Supplemental Social Security) NOT Social Security**

[ ] Other explain: _____ [ ] None

OTHER INFORMATION

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 #

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 Guest's current situation)

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

Please Fax this form to 973-998-5086