



Charity Tracker Intake Form

* Denotes Required Field:			
Case Record Information (Wizard Step 1 / 7)		Address Information (Wizard Step 4 / 7)	
Other Reference Number:		* Address Number:	
* Enrollment Date:		* Street:	
* Referral:		* City:	
Referral Comment:		* State:	
Head of Household Information (Wizard Step 2 / 7)		* Zip:	
* First Name:		Apt Complex:	
* Last Name:		Apt Number:	
* Date of Birth:	/ /	* Conference Boundary: <input type="checkbox"/> Inside <input type="checkbox"/> Outside	
* Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		SAFB Information (Wizard Step 4/7)	
* Race:	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Two or More Races	<input type="checkbox"/> Household is INELIGIBLE (Explain the reason for ineligibility in the "comments" box below.) INELIGIBLE Comments: <input type="checkbox"/> Household is ELIGIBLE based on: <input type="checkbox"/> Low Income <input type="checkbox"/> SNAP <input type="checkbox"/> SSI <input type="checkbox"/> Medicaid <input type="checkbox"/> NSLP <input type="checkbox"/> Temporary Crisis	
* Ethnicity:	<input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Non-Hispanic / Latino	Certification:	
Nationality: <i>New fields by SAFB</i>	<input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> South or Central American <input type="checkbox"/> Other Spanish Culture or Origin	The Certification period is up to twelve (12) months. However, for crisis food need, the certification period is up to six (6) months. The Texas department of Agriculture can approve crisis food need for seven (7) to twelve (12) months. Give the length of certification period if household is eligible.	
Marital Status:		Beginning Date: / / 20__	
Phone:		Ending Date: / / 20__	
ID Type <i>Drivers Lic, etc:</i>		Revisit form on this date: / / 20__	
ID State / Number:	/	Authorized Representative Name:	
Check if:	<input type="checkbox"/> Parishioner <input type="checkbox"/> Refugee	Authorized Representative Phone or Address:	
Military Status:	<input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Reserve <input type="checkbox"/> Veteran	Household Composition	
* Statistical Items: Check all that apply.	<input type="checkbox"/> Abuse Victim <input type="checkbox"/> Physically Disabled <input type="checkbox"/> Mentally Disabled <input type="checkbox"/> Chronic Physical Illness <input type="checkbox"/> Transient Homeless	<input type="checkbox"/> Two Parent Home <input type="checkbox"/> Senior(s) raising Grandchildren <input type="checkbox"/> Single Parent <input type="checkbox"/> Single Adult <input type="checkbox"/> Senior Living Alone	
Is this household member Currently Receiving Assistance from Other Sources?:	<input type="checkbox"/> TANF / AFDC <input type="checkbox"/> SNAP (Food Stamps) <input type="checkbox"/> SSI <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP <input type="checkbox"/> WIC <input type="checkbox"/> Section 8 <input type="checkbox"/> Social Security <input type="checkbox"/> NSLP <input type="checkbox"/> Temporary Crisis	**** FOR OFFICIAL USE ONLY - Do not write in steps 5 thru 7 ****	
SAFB Client Certification	Visit Information (Wizard Step 5 / 7)		
By signing below, I certify that: (1) I am a member of the household living at the address provided above and that, on behalf of the household, I apply for USDA Foods that are distributed through The Emergency Food Assistance Program; (2) all information provided to the agency determining my household's eligibility is, to the best of my knowledge and belief, true and correct; and (3) if applicable, the information provided by the household's "Authorized Representative" (as named below) is also, to the best of my knowledge and belief, true and correct.	* Type of Visit:	<input type="checkbox"/> Church <input type="checkbox"/> Phone <input type="checkbox"/> Home <input type="checkbox"/> Walk-in	
	* Visit Date:	/ / 20__	
	* Case Worker:		
	Visit Comment:		
	Assistance Information (Wizard Step 6 / 7)		
	* Item of Assistance:		
	* Quantity:		
	* Value (Each):		
	Comment:		
	Case Note (Wizard Step 7 / 7)		
	* Note Date if different:	/ / 20__	
	* By Staff:		
	* Case Note:		
	/ / 20__		
Client Signature (<i>Client must be present for initial interview and for all Food Assistance</i>)		Date	
Note: Additional Household Members Information (Wizard Step 3 / 7) on Next Page			



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Additional Household Members Information (Wizard Step 3 / 7) <i>Use additional sheets if necessary</i>			
* Denotes Required Field:			
Additional Member # _____		Additional Member # _____	
* Relationship to Head of Household: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild <input type="checkbox"/> Friend <input type="checkbox"/> Other	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild <input type="checkbox"/> Friend <input type="checkbox"/> Other	* Relationship to Head of Household: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild <input type="checkbox"/> Friend <input type="checkbox"/> Other	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild <input type="checkbox"/> Friend <input type="checkbox"/> Other
* First Name:		* First Name:	
* Last Name:		* Last Name:	
* Date of Birth: / /		* Date of Birth: / /	
* Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		* Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
* Race:		* Race:	
<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Two or More Races		<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Two or More Races	
* Ethnicity:		* Ethnicity:	
<input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Non-Hispanic / Latino		<input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Non-Hispanic / Latino	
Nationality: <i>New fields by SAFB</i>		Nationality: <i>New fields by SAFB</i>	
<input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> South or Central American <input type="checkbox"/> Other Spanish Culture or Origin		<input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> South or Central American <input type="checkbox"/> Other Spanish Culture or Origin	
Marital Status:		Marital Status:	
Phone:		Phone:	
ID Type <i>Drivers Lic, etc:</i>		ID Type <i>Drivers Lic, etc:</i>	
ID State / Number: /		ID State / Number: /	
Check if:		Check if:	
<input type="checkbox"/> Parishioner <input type="checkbox"/> Refugee		<input type="checkbox"/> Parishioner <input type="checkbox"/> Refugee	
Military Status:		Military Status:	
<input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Reserve <input type="checkbox"/> Veteran		<input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Reserve <input type="checkbox"/> Veteran	
* Statistical Items: Check all that apply.		* Statistical Items: Check all that apply.	
<input type="checkbox"/> Abuse Victim <input type="checkbox"/> Physically Disabled <input type="checkbox"/> Mentally Disabled <input type="checkbox"/> Chronic Physical Illness <input type="checkbox"/> Transient Homeless		<input type="checkbox"/> Abuse Victim <input type="checkbox"/> Physically Disabled <input type="checkbox"/> Mentally Disabled <input type="checkbox"/> Chronic Physical Illness <input type="checkbox"/> Transient Homeless	
Is this household member Currently Receiving Assistance from Other Sources?:		Is this household member Currently Receiving Assistance from Other Sources?:	
<input type="checkbox"/> TANF / AFDC <input type="checkbox"/> SNAP (Food Stamps) <input type="checkbox"/> SSI <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP <input type="checkbox"/> WIC <input type="checkbox"/> Section 8 <input type="checkbox"/> Social Security <input type="checkbox"/> NSLP <input type="checkbox"/> Temporary Crisis		<input type="checkbox"/> TANF / AFDC <input type="checkbox"/> SNAP (Food Stamps) <input type="checkbox"/> SSI <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP <input type="checkbox"/> WIC <input type="checkbox"/> Section 8 <input type="checkbox"/> Social Security <input type="checkbox"/> NSLP <input type="checkbox"/> Temporary Crisis	