 **PARTICIPANT INTAKE FORM**

#  OUR HEALTHY COMMUNITIES, INC.

****Today’s Date****

#  506 E Spruce / PO Box 778

 **Rogers, AR 72757**

 **PH: 479-636-7301 FAX: 479-636-7312**

 **PLEASE COMPLETE THE ENTIRE FORM**

|  |
| --- |
|  |
| Social Security # |  First Name MI Last Name | **Birth Date (mm/dd/yyyy)** |  **Age** | **Gender** |  Disabled |
| * -
 |  |  |  | 🞎Male 🞎Other🞎Female |  🞎Yes 🞎 No |
|  **Address**  |  | City | **State / Zip** | **Home #** | Cell # |
|  |  |  |  |  |  |
| **Race (Select One)** |  **Ethnicity** | Education  |  **Work Status**  |  **Health Coverage** | Veteran Status  |
| 🞎 White 🞎 Black🞎 Asian🞎 Other  | 🞎 Pacific Islanderor Native Hawaiian🞎 American Indian or Alaska Native🞎 Multi Race | 🞎 Hispanic orLatino🞎 NOT Hispanic  | 🞎 0 to 8th Grade🞎 9th - 12thGrade (non-grad)🞎 High School Grad/GED | 🞎12+ Post Secondary 🞎 College Graduate 2 or 4 year🞎 Graduate other Post Secondary School | 🞎 Youth 14-24 Not Working or in School🞎 Employed Full Time🞎 Employed Part Time🞎 Migrant Worker🞎 Unemployed 6 Months or Less🞎 Unemployed 6 Months or More 🞎 Unemployed Not Working 🞎 Retired  | 🞎 Medicare🞎 Medicaid🞎 State Health Insurance Children🞎 State Health Insurance Adults🞎Military Health Insurance🞎 Employment Based🞎 No Insurance | 🞎Yes🞎 No🞎Active Duty  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | Amount per Month |  Income Source**(Select Letter)** | Write the letter that corresponds with the income in the Income Source box for each individual |
|  | $ |  | **A** TANF**B** SSI-Social Security**C** SSD-Disability**D** VA Service - Disability**E** VA Non service - Disability**F** Private Disability Insurance**G** Workers Compensation  | **H** Retirement from Social Security**I** Pension **J** Child Support **K** Alimony or other spousal support **L** Employed – Full Time or Part Time **M** Self Employed**N** Unemployed**O** Other **(Describe)** |
|   | $ |  |
|  | $ |  |
|  | $ |  |
|  **Do you Received Snap Benefits** 🞎 Yes 🞎 No | $ | **Staff Use only:** Sources Verified: \_\_\_\_ Staff Initials: \_\_\_\_\_\_\_\_\_  Income Verified: \_\_\_\_ Corrected Amount $\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| **Total Household Income** |  | $ |  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|   Household Type (Select One) | Household Size | Housing |   |
| 🞎 Single Person🞎 Two Adults, No Children🞎 Single Parent Female🞎 Single Parent Male🞎 Two Parent Household | 🞎 Non Related Adults  with Children🞎 Multigenerational  Household🞎 Other  | 🞎 Single Person 🞎 Two 🞎 Three 🞎 Four 🞎 Five🞎 Six or more | 🞎 Own🞎 Rent🞎 Other Permanent Housing🞎 Homeless🞎 Other |  |

|  |
| --- |
|  **Highest Grade Completed****See Front Page for Options****See Front Page for Options****LIST ALL OTHER MEMBERS OF THE HOUSEHOLDS – DO NOT INCLUDE YOURSELF HERE:** **If you need additional space please request another intake form**.  |
| **Name (PLEASE PRINT)** | Social Security # | **Birth Date** | **Age** | Relationshipto Applicant | Gender |  Race | **Hispanic****or****Latino** |  **Disabled** | Health Insurance | **Type of Health Coverage** | Education |
| 1. | \_\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_ |  |  |  | M / F |   | 🞎 Yes 🞎 No | 🞎 Yes🞎 No |  🞎 Yes🞎 No  |  |   |
| 2. | \_\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_ |  |  |  | M / F |   | 🞎 Yes 🞎 No | 🞎 Yes🞎 No |  🞎 Yes🞎 No |  |   |
| 3. | \_\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_ |  |  |  | M / F |   | 🞎 Yes 🞎 No | 🞎 Yes🞎 No |  🞎 Yes🞎 No |  |   |
| 4. | \_\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_ |  |  |  | M / F |   | 🞎 Yes 🞎 No | 🞎 Yes🞎 No |  🞎 Yes🞎 No |  |   |
| 5. | \_\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_ |  |  |  | M / F |   | 🞎 Yes 🞎 No | 🞎 Yes🞎 No |  🞎 Yes🞎 No |  |   |

**OHC, Inc. receives funding from various sources and is required to provide these funding sources with statistical data on the clients we serve. YOUR PERSONAL INFORMATION IS KEPT STRICTLY CONFIDENTIAL.**

**I understand that disclosure of the above information is voluntary and will be used only for statistical purposes. The data compiled with other households will be used to create reports for OHC’s funding sources.**

**I certify that the income and other information provided on this form is correct at the time of this application.**

**Applicant Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPROVED DECLINED REASON FOR DENIAL**

**LIHEAP H2O CASE MANAGEMENT COVID-19**

 **APPROVED Declined Reason**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_