A. APPLICATION FOR ASSISTANCE

Page 1

All information on these pages will be kept strictly confidential.

NAME
Wife:_____Age:_____Birthday:_____

Husband:_____Age:_____Birthday:_____
OR
Legal Guardian:_____ Age: ____ Birthday: _____

Social Security Number: _____ Proof of guardianship ___ yes ___ no

Children:
1)_____School Attended:_____ Age:____ Grade:____

Transportation:_____ Birthday:_____

2)_____School Attended:_____ Age:____ Grade:____

Transportation:_____ Birthday:_____

3)_____School Attended:_____ Age:____ Grade:____

Transportation:_____ Birthday:_____

4)_____School Attended:_____ Age:____ Grade:____

Transportation:_____ Birthday:_____

5)_____School Attended:_____ Age:____ Grade:____

Transportation:_____ Birthday:_____

Please note if pre-schoolers attend Headstart or Kindergarten/Nursery program and their means of transportation.

Martial Status: Married____ Single____ Divorced ____ Widowed____ Other____
If divorced, who has legal custody of the child(ren)? _____
Proof of custody ___ yes ___ no

Address:_____ Mailing Address:_____

Directions:_____

_____

Phone Number:_____

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Husband's Employer: _____
Phone Number:_____

Wife's Employer: _____
Phone Number:_____

Or, Guardian's Employer: _____
Phone Number: _____
Address: _____

Rent or Own Home:_____ Monthly Rent or Payment_____

Family Income:
Job Income Yes___ No___ Monthly $ _____

Financial Assistance:

Welfare	Yes___ No___	Monthly $ _____
Social Security	Yes___ No___	Monthly $ _____
Food Stamps	Yes___ No___	Monthly $ _____
Aid to Dependent Children	Yes___ No___	Monthly $ _____
Other Assistance	Yes___ No___	Monthly $ _____

Other Income: _____ Yes___ No___ Monthly $ _____

Case Worker: _____
Phone Number: _____

Bills: Utilities _____
Other _____
_____
_____

Transportation:

Own Car Yes___ No___
If no, explain means of transportation, if any.
_____
_____
_____

Insurance:

Auto:	Yes___ No___	Coverage $_____
Liability	Yes___ No___	Coverage $_____
Collision	Yes___ No___	Coverage $_____
Other	Yes___ No___	Coverage $_____
Major Medical:	Yes___ No___	Coverage $_____
Hospitalization:	Yes___ No___	Coverage $_____
Life:	Yes___ No___	Coverage $_____
Dental:	Yes___ No___	Coverage $_____

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Husband/Guardian:
Education: High School: Yes___ No___ Last Grade Attended:_____
College: Yes___ No___ Degree_____

Wife/Guardian:
Education: High School: Yes___ No___ Last Grade Attended_____
College: Yes___ No___ Degree_____
Trade or Special Training:_____
Previous Employment:_____

Someone to notify in emergency (not residing with you).
Name:_____ Phone Number:_____
Address:_____

Medical facility family is currently using:_____
_____
Any medical Needs:
Long Term:_____
Short Term:_____
Doctor:
Name:_____ Phone Number:_____
Address:_____

Children's Doctor:
Name:_____ Phone Number:_____
Address:_____

Dentist:
Name:_____ Phone Number:_____
Address:_____

Family Sizes:
Mother/Guardian Blouse_____ Skirt_____ Dress_____ Pants_____
Coat_____ Shoes_____ Undergarments_____

Father/Guardian: Shirt_____ Pants_____ Coat_____ Shoes_____
Belt____ Undergarments_____

Daughter: Blouse_____ Skirt_____ Dress_____ Pants_____
Coat_____ Shoes_____ Undergarments_____

Son: Shirt_____ Pants_____ Coat_____ Shoes_____
Belt____ Undergarments_____

(ANY OTHER WRITE ON SEPARATE SHEET)

B. GOALS

TO BE REVIEWED ANNUALLY

IMMEDIATE NEEDS:

LONG TERM NEEDS:

PROBLEMS: (Internal or External)

OBSERVATIONS: