



Eastern Idaho Community Action Partnership

Universal Intake Form

How did you hear about us?

- Social Media
 Newspaper
 Radio
 Poster/Flyer
 Referred by Family/Friend
 Referred by Another Agency
 Referred by Utility Company
 Other (please state): _____

What EICAP program(s) are you interested in?

- Early Head Start
 Head Start
 Senior Services Information & Assistance
 Caregiver Services
 Senior Meal Services
 Energy Assistance/Crisis
 Water Assistance
 Food Pantry
 Tuition Assistance
 Rental Assistance
 Weatherization

Household Information			
Name:			
MAILING Address:			
City:		State: IDAHO	Zip Code:
PHYSICAL Address: (If different than mailing address)			
City:	County:	State: IDAHO	Zip Code:
Home Phone:	Cell Phone:	Ok to contact by text? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email:		Ok to contact by email? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary Language:		Secondary Language:	
Emergency Contact/Proxy:			
Name:		Phone #:	
Household Type:			
<input type="checkbox"/> Single Person	<input type="checkbox"/> Single Parent (Male)	<input type="checkbox"/> Multi-generational Household	
<input type="checkbox"/> 2 Adults (no kids)	<input type="checkbox"/> Two Parent Household	<input type="checkbox"/> Foster Parents	
<input type="checkbox"/> Single Parent (Female)	<input type="checkbox"/> Nonrelated Adults w/kids	<input type="checkbox"/> Grand Parents raising Grand Children	
<input type="checkbox"/> Other _____			
Current Housing Status:		Current Housing Situation:	
<input type="checkbox"/> Stably Housed	<input type="checkbox"/> At imminent risk of losing housing	<input type="checkbox"/> Own	<input type="checkbox"/> Living/ Staying with another
<input type="checkbox"/> At Risk of homelessness	<input type="checkbox"/> Homeless	<input type="checkbox"/> Rent (No Subsidy)	<input type="checkbox"/> Emergency Shelter
		<input type="checkbox"/> Rent (Subsidized)	<input type="checkbox"/> Long Term Care Facility
		<input type="checkbox"/> Place not meant for habitation	
		<input type="checkbox"/> Substance abuse treatment facility/ Detox center	
Total Number of Household Members			
<i>Please provide details regarding those who live in your home on additional pages.</i>			

Household Members- Please provide details regarding <u>everyone</u> who lives in your home. Pages for additional household members are available.		
Relationship to Head of Household	Applicant/ Head of Household	2 nd Household Member
Name		
Date of Birth		
Social Security # Verified?		
Ethnicity	<input type="checkbox"/> Hispanic, Latin(a)(o)(x) <input type="checkbox"/> Not Hispanic, Latin(a)(o)(x)	<input type="checkbox"/> Hispanic, Latin(a)(o)(x) <input type="checkbox"/> Not Hispanic, Latin(a)(o)(x)
Race	<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <i>Tribal Affiliation: _____</i> <input type="checkbox"/> Native Hawaiian & Other Pacific Islander <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Other _____	<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <i>Tribal Affiliation: _____</i> <input type="checkbox"/> Native Hawaiian & Other Pacific Islander <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Other _____
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
U.S. Citizenship	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Qualified Alien	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Qualified Alien
Military Status	<input type="checkbox"/> Veteran <input type="checkbox"/> Active Military <input type="checkbox"/> N/A	<input type="checkbox"/> Veteran <input type="checkbox"/> Active Military <input type="checkbox"/> N/A
Disabling Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Non-Cash Benefits (Please check ALL that Apply)	<input type="checkbox"/> SNAP (Food Stamps) <input type="checkbox"/> WIC <input type="checkbox"/> Childcare Voucher <input type="checkbox"/> Housing Choice Voucher <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> HUD-VASH <input type="checkbox"/> Affordable Care Act. Subsidy <input type="checkbox"/> LIHEAP <input type="checkbox"/> Other _____	<input type="checkbox"/> SNAP (Food Stamps) <input type="checkbox"/> WIC <input type="checkbox"/> Childcare Voucher <input type="checkbox"/> Housing Choice Voucher <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> HUD-VASH <input type="checkbox"/> Affordable Care Act. Subsidy <input type="checkbox"/> LIHEAP <input type="checkbox"/> Other _____
Health Insurance (Please check ALL that Apply)	<input type="checkbox"/> Medicaid <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Medicare <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Employer Provide Health Insurance <input type="checkbox"/> VA Medical Services <input type="checkbox"/> Indian Health Service Program <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Other _____	<input type="checkbox"/> Medicaid <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Medicare <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Employer Provide Health Insurance <input type="checkbox"/> VA Medical Services <input type="checkbox"/> Indian Health Service Program <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Other _____
Education (For those 16+ Check ALL that Apply)	<input type="checkbox"/> Grades 0-8 <input type="checkbox"/> Grades 9-12 / Non-Graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> Equivalency Diploma <input type="checkbox"/> 12 grade + Some post- Secondary <input type="checkbox"/> Graduate of other Post-Secondary school <input type="checkbox"/> 2 or 4 year College Graduate	<input type="checkbox"/> Grades 0-8 <input type="checkbox"/> Grades 9-12 / Non-Graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> Equivalency Diploma <input type="checkbox"/> 12 grade + Some post- Secondary <input type="checkbox"/> Graduate of other Post-Secondary school <input type="checkbox"/> 2 or 4 year College Graduate
Currently in School? Do you receive scholarships or grants?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

Household Members- Please provide details regarding <u>everyone</u> who lives in your home. Pages for additional household members are available.		
Relationship to Head of Household	3 rd Household Member	4 th Household Member
Name		
Date of Birth		
Social Security # Verified?		
Ethnicity	<input type="checkbox"/> Hispanic, Latin(a)(o)(x) <input type="checkbox"/> Not Hispanic, Latin(a)(o)(x)	<input type="checkbox"/> Hispanic, Latin(a)(o)(x) <input type="checkbox"/> Not Hispanic, Latin(a)(o)(x)
Race	<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native Tribal Affiliation: _____ <input type="checkbox"/> Native Hawaiian & Other Pacific Islander <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Other _____	<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native Tribal Affiliation: _____ <input type="checkbox"/> Native Hawaiian & Other Pacific Islander <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Other _____
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
U.S. Citizenship	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Qualified Alien	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Qualified Alien
Military Status	<input type="checkbox"/> Veteran <input type="checkbox"/> Active Military <input type="checkbox"/> N/A	<input type="checkbox"/> Veteran <input type="checkbox"/> Active Military <input type="checkbox"/> N/A
Disabling Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Non-Cash Benefits Please check ALL that Apply)	<input type="checkbox"/> SNAP (Food Stamps) <input type="checkbox"/> WIC <input type="checkbox"/> Childcare Voucher <input type="checkbox"/> Housing Choice Voucher <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> HUD-VASH <input type="checkbox"/> Affordable Care Act. Subsidy <input type="checkbox"/> LIHEAP <input type="checkbox"/> Other _____	<input type="checkbox"/> SNAP (Food Stamps) <input type="checkbox"/> WIC <input type="checkbox"/> Childcare Voucher <input type="checkbox"/> Housing Choice Voucher <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> HUD-VASH <input type="checkbox"/> Affordable Care Act. Subsidy <input type="checkbox"/> LIHEAP <input type="checkbox"/> Other _____
Health Insurance (Please check ALL that Apply)	<input type="checkbox"/> Medicaid <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Medicare <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Employer Provide Health Insurance <input type="checkbox"/> VA Medical Services <input type="checkbox"/> Indian Health Service Program <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Other _____	<input type="checkbox"/> Medicaid <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Medicare <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Employer Provide Health Insurance <input type="checkbox"/> VA Medical Services <input type="checkbox"/> Indian Health Service Program <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Other _____
Education (For those 16+ Check ALL that Apply)	<input type="checkbox"/> Grades 0-8 <input type="checkbox"/> Grades 9-12 / Non-Graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> Equivalency Diploma <input type="checkbox"/> 12 grade + Some post- Secondary <input type="checkbox"/> Graduate of other Post-Secondary school <input type="checkbox"/> 2 or 4 year College Graduate	<input type="checkbox"/> Grades 0-8 <input type="checkbox"/> Grades 9-12 / Non-Graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> Equivalency Diploma <input type="checkbox"/> 12 grade + Some post- Secondary <input type="checkbox"/> Graduate of other Post-Secondary school <input type="checkbox"/> 2 or 4 year College Graduate
Currently in School?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you receive scholarships or grants?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Household Monthly Income – Please provide details regarding everyone in your home that has an income. If there are more household members that cannot be included on this form, please ask for another page.

Household Member:	Applicant/Head of Household	2 nd Member Name:	3 rd Member Name:	4 th Member Name:
Employment Type (For those 18+ Check ALL that Apply)	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self-employed <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Unemployed < 6 months <input type="checkbox"/> Unemployed > 6 months <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed (Not in Labor Force)	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self-employed <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Unemployed < 6 months <input type="checkbox"/> Unemployed > 6 months <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed (Not in Labor Force)	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self-employed <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Unemployed < 6 months <input type="checkbox"/> Unemployed > 6 months <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed (Not in Labor Force)	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self-employed <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Unemployed < 6 months <input type="checkbox"/> Unemployed > 6 months <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed (Not in Labor Force)
Income Sources: <i>Check all that apply and fill out total monthly income</i>	<input type="checkbox"/> No Financial Resources <input type="checkbox"/> Earned Income \$ _____ <input type="checkbox"/> Social Security (Retirement/Survivor) \$ _____ <input type="checkbox"/> SSDI \$ _____ <input type="checkbox"/> SSI \$ _____ <input type="checkbox"/> AABD \$ _____ <input type="checkbox"/> VA Benefits \$ _____ <input type="checkbox"/> TANF/TAFI \$ _____ <input type="checkbox"/> Child Support \$ _____ <input type="checkbox"/> Alimony \$ _____ <input type="checkbox"/> Pension/Retirement \$ _____ <input type="checkbox"/> Annuity \$ _____ <input type="checkbox"/> Unemployment \$ _____ <input type="checkbox"/> Workers Compensation \$ _____ <input type="checkbox"/> Private Disability Insurance \$ _____ <input type="checkbox"/> Grandparent Benefit \$ _____ <input type="checkbox"/> Foster Parent Income \$ _____ <input type="checkbox"/> General Assistance \$ _____ <input type="checkbox"/> Interest \$ _____ <input type="checkbox"/> Grants/Scholarships \$ _____	<input type="checkbox"/> No Financial Resources <input type="checkbox"/> Earned Income \$ _____ <input type="checkbox"/> Social Security (Retirement/Survivor) \$ _____ <input type="checkbox"/> SSDI \$ _____ <input type="checkbox"/> SSI \$ _____ <input type="checkbox"/> AABD \$ _____ <input type="checkbox"/> VA Benefits \$ _____ <input type="checkbox"/> TANF/TAFI \$ _____ <input type="checkbox"/> Child Support \$ _____ <input type="checkbox"/> Alimony \$ _____ <input type="checkbox"/> Pension/Retirement \$ _____ <input type="checkbox"/> Annuity \$ _____ <input type="checkbox"/> Unemployment \$ _____ <input type="checkbox"/> Workers Compensation \$ _____ <input type="checkbox"/> Private Disability Insurance \$ _____ <input type="checkbox"/> Grandparent Benefit \$ _____ <input type="checkbox"/> Foster Parent Income \$ _____ <input type="checkbox"/> General Assistance \$ _____ <input type="checkbox"/> Interest \$ _____ <input type="checkbox"/> Grants/Scholarships \$ _____	<input type="checkbox"/> No Financial Resources <input type="checkbox"/> Earned Income \$ _____ <input type="checkbox"/> Social Security (Retirement/Survivor) \$ _____ <input type="checkbox"/> SSDI \$ _____ <input type="checkbox"/> SSI \$ _____ <input type="checkbox"/> AABD \$ _____ <input type="checkbox"/> VA Benefits \$ _____ <input type="checkbox"/> TANF/TAFI \$ _____ <input type="checkbox"/> Child Support \$ _____ <input type="checkbox"/> Alimony \$ _____ <input type="checkbox"/> Pension/Retirement \$ _____ <input type="checkbox"/> Annuity \$ _____ <input type="checkbox"/> Unemployment \$ _____ <input type="checkbox"/> Workers Compensation \$ _____ <input type="checkbox"/> Private Disability Insurance \$ _____ <input type="checkbox"/> Grandparent Benefit \$ _____ <input type="checkbox"/> Foster Parent Income \$ _____ <input type="checkbox"/> General Assistance \$ _____ <input type="checkbox"/> Interest \$ _____ <input type="checkbox"/> Grants/Scholarships \$ _____	<input type="checkbox"/> No Financial Resources <input type="checkbox"/> Earned Income \$ _____ <input type="checkbox"/> Social Security (Retirement/Survivor) \$ _____ <input type="checkbox"/> SSDI \$ _____ <input type="checkbox"/> SSI \$ _____ <input type="checkbox"/> AABD \$ _____ <input type="checkbox"/> VA Benefits \$ _____ <input type="checkbox"/> TANF/TAFI \$ _____ <input type="checkbox"/> Child Support \$ _____ <input type="checkbox"/> Alimony \$ _____ <input type="checkbox"/> Pension/Retirement \$ _____ <input type="checkbox"/> Annuity \$ _____ <input type="checkbox"/> Unemployment \$ _____ <input type="checkbox"/> Workers Compensation \$ _____ <input type="checkbox"/> Private Disability Insurance \$ _____ <input type="checkbox"/> Grandparent Benefit \$ _____ <input type="checkbox"/> Foster Parent Income \$ _____ <input type="checkbox"/> General Assistance \$ _____ <input type="checkbox"/> Interest \$ _____ <input type="checkbox"/> Grants/Scholarships \$ _____

Zero Income Declaration - Please complete if everyone in your household had no income over the previous three months
 Note: If your household also declared zero income in the prior year, additional information may be required.

I DECLARE THAT THE GROSS INCOME FOR MY HOUSEHOLD HAS BEEN ZERO FOR THE PREVIOUS 3 MONTHS.
 I understand that willful misrepresentation and/or concealment of facts can result in criminal and civil penalties.
 My household's basic living needs for the previous 3 months have been met by: (Give a brief explanation below)

Shelter		Food		Utilities	
Participant Signature				Date	

I certify that the information above is correct and true to the best of my knowledge and understand that further verification for EICAP programs may be required for participation in those programs.

By completing this application, I give permission to EICAP to refer my household to any services available with EICAP programs.

Are you willing to make a long-term commitment to share feedback? Yes No

Participant Signature				Date	
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Office Use Only: Verbal Verification Yes No Intake for verbal: