OFFICE USE ONLY: Date of Intake Client ID# Intake Worker	FICE USE ONLY:	ONLY: Date of Intake	Client ID#	Intake Worker
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Universal Intake Form

How did you hear about us?				
☐ Social Media ☐ Newspaper ☐ Radio ☐ Poster/Flyer ☐ Referred by Family/Friend				
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What EICAP program(s) are you interested in?				
☐ Early Head Start ☐ Head Start ☐ Senior Services Info	rmation & Assistance $\ \Box$	Caregiver Service	es Senior Meal Services	
☐ Energy Assistance/Crisis ☐ Food Pantry ☐ Medical Ass	sistance 🛚 Rental Assista	ance 🛚 Tuition A	ssistance \square Weatherization	
Housel	hold Information			
Name:				
MAILING Address:				
City:		State: IDAHO	Zip Code:	
PHYSICAL Address:				
(If different than mailing address)				
City:	County:	State: IDAHO	Zip Code:	
Primary		Ok to contact	by text? ☐ Yes ☐ No	
	Cell \square Home \square Work			
Email: Ok to contact by email		by email? ☐ Yes ☐ No		
Primary Language:	Secondary Language:			
Emergency				
Contact/Proxy: Name:	Pho	one #:		
Household Type:	ds) \ Multi	gonorational Ho	ucobold	
☐ Single Person ☐ Two Adults (no kids) ☐ Multi-generational Household ☐ Single Parent (Male) ☐ Two Parent Household ☐ Foster Parents			userioiu	
☐ Single Parent (Female) ☐ Nonrelated Adults w/kids ☐ Grand Parents raising Grand Children			Grand Children	
□ Other	,	o o		
Current Housing Status:	Current Housing Situa	ntion:		
☐ Stably Housed	☐ Own ☐ Living/ Staying with another		Staying with another	
\square At imminent risk of losing housing	☐ Rent (No Subsidy) ☐ Emergency Shelter		ency Shelter	
☐ At Risk of homelessness	\square Rent (Subsidized) \square Long Term Care Facility			
☐ Homeless ☐ Place not meant for habitation				
	☐ Substance abuse tr	eatment facility,	/ Detox center	
Total Number of Household Members				
Please provide details reaardina tha	se who live in vour hor	ne on additiona	l pages.	

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

Household Members- Please provide details regarding everyone who lives in your home. Pages for additional			
household members are	available.		
Relationship to	3 rd Household	4 th Household	
Head of Household	Member	Member	
Name			
Date of Birth			
Social Security # Verified?			
Ethnicity	☐ Hispanic, Latin(a)(o)(x)	☐ Hispanic, Latin(a)(o)(x)	
,	☐ Not Hispanic, Latin(a)(o)(x)	☐ Not Hispanic, Latin(a)(o)(x)	
Race	☐ White	☐ White	
	☐ Black or African American	☐ Black or African American	
Please check ALL that Apply	☐ American Indian or Alaska Native	☐ American Indian or Alaska Native	
	Tribal Affiliation:	Tribal Affiliation:	
	☐ Native Hawaiian & Other Pacific Islander	☐ Native Hawaiian & Other Pacific Islander	
	☐ Asian or Asian American	☐ Asian or Asian American	
	☐ Other	☐ Other	
Gender	☐ Male ☐ Female ☐ Other	☐ Male ☐ Female ☐ Other	
U.S. Citizenship	☐ Yes ☐ No ☐ Qualified Alien	☐ Yes ☐ No ☐ Qualified Alien	
Military Status	☐ Veteran ☐ Active Military ☐ N/A	☐ Veteran ☐ Active Military ☐ N/A	
Disabling Condition	☐ Yes ☐ No	☐ Yes ☐ No	
Non-Cash Benefits	☐ SNAP (Food Stamps)	☐ SNAP (Food Stamps)	
	□ wic	□ WIC	
Please check ALL that Apply	☐ Childcare Voucher	☐ Childcare Voucher	
	☐ Housing Choice Voucher	☐ Housing Choice Voucher	
	☐ Permanent Supportive Housing	☐ Permanent Supportive Housing	
	☐ HUD-VASH	☐ HUD-VASH	
	☐ Affordable Care Act. Subsidy	☐ Affordable Care Act. Subsidy	
	LIHEAP	LIHEAP	
	☐ Other	☐ Other	
Health Insurance	☐ Medicaid	☐ Medicaid	
	☐ State Health Insurance for Adults	☐ State Health Insurance for Adults	
Please check ALL that	☐ Medicare	☐ Medicare	
Apply	☐ Private Pay Health Insurance	☐ Private Pay Health Insurance	
	☐ State Children's Health Insurance Program	☐ State Children's Health Insurance Program	
	☐ Employer Provide Health Insurance	☐ Employer Provide Health Insurance	
	☐ VA Medical Services	☐ VA Medical Services	
	☐ Indian Health Service Program	☐ Indian Health Service Program	
	☐ Health Insurance Obtained through COBRA	☐ Health Insurance Obtained through COBRA	
	☐ Other	☐ Other	
Education	☐ Grades 0-8	☐ Grades 0-8	
	☐ Grades 9-12 / Non-Graduate	☐ Grades 9-12 / Non-Graduate	
For those 16+ Check ALL that	☐ High School Graduate	☐ High School Graduate	
Apply	☐ Equivalency Diploma	☐ Equivalency Diploma	
	☐ 12 grade + Some post- Secondary	☐ 12 grade + Some post- Secondary	
	☐ Graduate of other Post-Secondary school	☐ Graduate of other Post-Secondary school	
	☐ 2 or 4 year College Graduate	☐ 2 or 4 year College Graduate	
Currently in School?	☐ Yes ☐ No	☐ Yes ☐ No	
Do you receive			
scholarships or grants?	☐ Yes ☐ No	☐ Yes ☐ 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.				
	Applicant/Head of	2 nd Member Name:	3 rd Member Name:	4 th Member Name:
Household	Household	Z ^{na} Weiliber Name.	5 Vielliber Name.	4 ··· Welliber Name.
Member:				
Employment	☐ Full Time ☐ Part Time	☐ Full Time ☐ Part Time	☐ Full Time ☐ Part Time	☐ Full Time ☐ Part Time
Type	☐Self-employed	☐Self-employed	☐Self-employed	☐Self-employed
	☐Migrant Seasonal Farm	☐ Migrant Seasonal Farm	☐ Migrant Seasonal Farm	☐ Migrant Seasonal Farm
For those 18+	Worker	Worker	Worker	Worker
Check ALL that	☐Unemployed < 6 months	\Box Unemployed < 6 months	☐Unemployed < 6 months	☐Unemployed < 6 months
Apply	\square Unemployed > 6 months	☐Unemployed > 6 months	☐Unemployed > 6 months	☐Unemployed > 6 months
	□Retired	□Retired	□Retired	□Retired
	☐Unemployed (Not in	☐Unemployed (Not in	☐Unemployed (Not in	☐Unemployed (Not in
	Labor Force	Labor Force	Labor Force	Labor Force
Income	☐ No Financial Resources	☐ No Financial Resources	☐ No Financial Resources	☐ No Financial Resources
Sources	☐ Earned Income	☐ Earned Income	☐ Earned Income	☐ Earned Income
Jources	\$	\$	\$	\$
Check all that	☐ Social Security	☐ Social Security	☐ Social Security	☐ Social Security
apply and fill	(Retirement/Survivor)	(Retirement/Survivor)	(Retirement/Survivor)	(Retirement/Survivor)
out total	\$	\$	\$	¢
monthly	□ SSDI	□ SSDI	□ SSDI	□ SSDI
income	\$	\$	\$	\$
	□ SSI	□ SSI	□ SSI	□ SSI
	\$	\$	\$	\$
	□ AABD	□ AABD	□ AABD	□ AABD
	\$	\$	\$	\$
	□ VA Benefits	□ VA Benefits	□ VA Benefits	□ VA Benefits
	\$	\$	\$	c va belieffts
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	☐ TANF/TAFI	☐ TANF/TAFI	☐ TANF/TAFI	☐ TANF/TAFI
	Child Company	Child Supposet	Child Supposet	Child Cup and
	☐ Child Support	☐ Child Support	☐ Child Support	☐ Child Support
	Aline a mu	Alima a mu	Alima a mu	>
	Alimony	Alimony	Alimony	Alimony
	☐ Pension/Retirement	☐ Pension/Retirement	☐ Pension/Retirement	☐ Pension/Retirement
	rension/ketirement	bension/Retirement	e Pension/Retirement	c Pension/Retirement
	Appuitu	Appuitu	Appuity	Appuitu
	Annuity	☐ Annuity	☐ Annuity	☐ Annuity
	□ Unemployment	☐ Unemployment	☐ Unemployment	☐ Unemployment
	diemployment	c onemployment	c onemployment	c onemployment
	☐ Workers Compensation	☐ Workers Compensation	☐ Workers Compensation	☐ Workers Compensation
	c workers compensation	workers compensation	workers compensation	c workers compensation
	☐ Private Disability	☐ Private Disability	☐ Private Disability	☐ Private Disability
	Insurance	Insurance	Insurance	Insurance
	Ś	\$	Ś	¢
	☐ Grandparent Benefit	☐ Grandparent Benefit	☐ Grandparent Benefit	☐ Grandparent Benefit
	drandparent benefit	dianaparent benefit	dianaparent benefit	c dranaparent benefit
	☐ Foster Parent Income	☐ Foster Parent Income	☐ Foster Parent Income	☐ Foster Parent Income
	c coster rateful illicomie	c c	c c	ė
	☐ General Assistance	☐ General Assistance	☐ General Assistance	☐ General Assistance
	c delicial Assistance	\$	c delicial Assistance	c deneral Assistance
	□ Interest	□ Interest	□ Interest	□ Interest
	c interest	s interest	s interest	\$
	Grants/Scholarchins	т	Т	'
	☐ Grants/Scholarships	☐ Grants/Scholarships	☐ Grants/Scholarships	☐ Grants/Scholarships
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Zero Income Declaration - Please complete this section only if all household members in your home had no			
income in the previous month.		·	
Note: If your household also declared	zero income in the prior year, addition	nal information may be required.	
I DECLARE THAT THE GROSS INCOME FO	R MY HOUSEHOLD HAS BEEN ZERO FOR	THE PREVIOUS MONTH.	
I understand that willful misrepresentati	ion and/or concealment of facts can resu	lt in criminal and civil penalties.	
My household's basic living needs for the	e previous month have been met by: (Giv	ve a brief explanation below)	
Shelter	Food	Utilities	
Participant		Date	
Signature			
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	

Office Use Only: Verbal Verification \square Yes \square No Intake for verbal: