TELL US IN YOUR OWN WORDS....

WHAT IS THE REASON THAT YOU NEI	ED HELP FOR CHRISTMAS?
OFFICE USE ONLY — COMMENTS:	INTAKE
	PAID FINANCIAL HOUSEHOLD

	ne of Head lousehold			First			_ SS _		DOB			
Add	Last First Address Apt/Trailer Lot #											
City	City State Zip County											
Pho	one 1 (& name)					Phone	2 (& na	ame)				
Eme	ergency phone & name	e				Ema	il					
	Household Members First & Last Names	Sex M/F	Relation to you	Date of Birth (mm/dd/yy)	Shirt Size	Pant Size	Shoe Size	Grade & School	Special Needs / 3 to 5 Gift Ideas For Santa			
1			self									
2												
3												
4												
5												
6	6											
7												
8												
9												
1 0												
Do	you need food assistar	nce? Y	es No_	Specify	types o	f food r	eeded:		· · · · · · · · · · · · · · · · · · ·			
		 										
Do	you need any basic ho	usehol	d items? L	ist items need	led <u>if ac</u>	lopter c	hooses	to provide	additional gifts (size when appropriate):			

Head of Household Marital Status ✓		Race ✓ (check all the	hat a	pply)	Military Service/Veteran ✓				
Married	Divorced		White		Native American	Air Force		Marines	
Never Married	Widow(er)		Black		Asian	Army		Navy	
Separated	Single		Hispanic/Latino		Multi-racial household	Guard		Reserves	

	Employment histor	v of all adults	(Current and past y	ear)
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Does any household member have deductions/garnishments/child support taken from wages after taxes? No Name Type of garnishment/deduction Type or cause of disability	nployee	Employer	Starting	End date/ Still working	¢ por hour	# hours worked in a pay period	How often paid	Gross	Net
Type of garnishment/deduction Type or cause of disability HOW OFTEN PAID In AME OF PERSON RECEIVING HOW OFTEN PAID IN AME OF PERSO	ipioyee	Employer	mo & year	Juli Working	\$ per hour	a pay positou	paid	wages	wages
Type of garnishment/deduction Type or cause of disability NAME OF PERSON RECEIVING HOW OFTEN PAID Ind Pension Ind Pension Ind Support or Alimony Ilitary Allotment Index or relatives/organizations Type or cause of disability HOW OFTEN PAID Index or relatives Index									
Type of garnishment/deduction Type of garnishment/deduction Type of garnishment/deduction Type of garnishment/deduction Type or cause of disability Type or cause of disab	nes any housel	oold member have dec	ductions/garnish	ments/child	support take	n from wages	ofter taxes?	No. V	26
Type of garnishment/deduction Description in your household receive disability benefits? Yes No Type or cause of disability DISTRICT INCOME SOURCES	•		-			-		110 16	,,,
Des anyone in your household receive disability benefits? Yes No ame Type or cause of disability DITHLY INCOME SOURCES									
Type or cause of disability NAME OF PERSON RECEIVING HOW OFTEN PAID Ind Pension How OFTEN PAID Independent of Alimony Horey from relatives/organizations How Often PAID How Often P				•					
Type or cause of disability Type or cause of disability Type or cause of disability NAME OF PERSON RECEIVING HOW OFTEN PAID Ind Pension hild Support or Alimony iilitary Allotment loney from relatives/organizations ension/Retirement ental/Property Income locial Security SI/Disability Benefits ANF or Foster Care nemployment Compensation nemployed Fathers tility Allowance from Housing eteran's Pension /orkmen's Compensation ther, Specify:	•		-						
Type or cause of disability DNTHLY INCOME SOURCES NAME OF PERSON RECEIVING HOW OFTEN PAID									
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eteran's Pension /orkmen's Compensation ther, Specify:	nemployed F	athers							
/orkmen's Compensation ther, Specify:									
ther, Specify:									
· ·									
OFFICE USE ONLY:								0.70	DUEDI
	FFICE USE (JNLY:						\$10	P HERI
TOTAL HOUSEHOLD INCOME \$					TOTAL	HOUSEHOL	D INCOME	\$	
dented and necessary could you come to our office to pick up any gifts you might receive 2 No.	dented and re-	account accord you as	omo to cur offic	o to pick up	ony citto	u miaht roos!	(o2 No	Voc	
dopted and necessary, could you come to our office to pick-up any gifts you might receive? No Yes nyone in your household on probation or parole? No Yes Who?							er No	165	
me and phone of landlord, employer, or caseworker that can verify your information if necessary:							cessary:		
	ne and prione								

re authority as the original. I certify that all the information I provided is true and correct to the best of my knowledge and understand that deliberate false or misleading information will be cause for refusal of services.

Print Name	
Signature	Date
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PLEASE COMPLETE THIS PAGE - PRINT CLEARLY

MONTHLY EXPENSES	CURRENT AMOUNT DUE	PAST DUE AMOUNT	SHUT OFF DATE	OFFICE USE ONLY
MORTGAGE/RENT (CIRCLE ONE)	\$	\$		
IF SUBSIDIZED: AMOUNT YOU PAY CAR — YEAR — MAKE & MODEL				
CAR – YEAR – MAKE & MODEL				
INSURANCE – CAR				
# MONTHS PAYMENT COVERS	/ MOS			
INSURANCE - HOME/RENTERS				
# MONTHS PAYMENT COVERS	/ MOS			
INSURANCE – HEALTH # MONTHS PAYMENT COVERS				
INSURANCE – LIFE	/ MOS			
# MONTHS PAYMENT COVERS	/ MOS			
ELECTRICITY	, IMOG			
GAS/PROPANE				
WATER				
SEWER				
TRASH				
# MONTHS PAYMENT COVERS	/ MOS			
CABLEVISION/INTERNET				
HOME/CELL PHONE NUMBER OF PHONES				
CREDIT CARD: NAME OF				
PAYDAY/TITLE LOAN				
LOAN: FOR WHAT				
RENT-TO-OWN: ITEM(S)				
FOOD - AFTER USING FOOD STAMPS		AMOUNT OF FOOD STAMP	S RECEIVED \$	
PRESCRIPTIONS/CO-PAYS				
MONTHLY MEDICAL EXPENSES (CO-PAYS, DOCTOR PAYMENTS)				
CHILD CARE (DAYCARE/BABYSITTER)				
TRANSPORTATION: GAS/BUS/CAB				
(CIRCLE ONE OR MORE)				
SCHOOL LUNCHES				
SCHOOL ACTIVITY EXPENSES				
LAUNDROMAT EXPENSES				
CLEANING SUPPLIES				
PERSONAL HYGIENE (INCLUDE TANNING/NAILS)				
DIAPERS				
CIGARETTES				
PET FOOD				
LEGAL/COURT FINES				
OTHER (PLEASE LIST)				
TOTALS				