



APPLICATION FORM FOR NEW CLIENTS

REFERRED BY _____ DATE _____

NAME _____ SPOUSE NAME _____

ADDRESS _____

CITY _____ ZIP CODE _____ COUNTY _____

TYPE OF ADDRESS _____ (P -permanent, T-temporary, N-no address)

PHONE home _____ cell _____ work _____ email _____

YOUR EMPLOYER _____ YOUR MONTHLY INCOME _____

SPOUSE'S EMPLOYER _____ SPOUSE'S MONTHLY INCOME _____

DRIVERS LICENSE or ID# _____ DATE OF BIRTH _____

GENDER M ___ F ___

ETHNICITY _____ (B-black, S-Hispanic, C-Caucasian, A- American Indian, I-Asian, O-other)

PRIMARY LANGUAGE _____

NUMBER OF ADULTS 18 and older _____

NUMBER OF LEGALLY DEPENDENT CHILDREN 17 and younger _____

MARITAL STATUS _____ (M-married, S-single, L-separated, D-divorced, C-co-habitant, O-other)

VETERAN yes ___ no ___ DISABLED yes ___ no ___

ARE THERE OTHER DISABLED ADULTS IN THE HOUSEHOLD? Yes ___ no ___

Type of household, indicate below

two parent

elderly

one parent

pregnant

couple with pregnancy

temporarily disabled

couple without pregnancy

permanently disabled

other

single

NAMES and BIRTHDATES of CHILDREN

Name	Relationship	Birth date

DO YOU ATTEND CHURCH? Yes ___ No ___ CHURCH NAME _____

If you do not attend church would be interested in being connected with a church? Yes ___ No ___

What denomination of church of church would you prefer? _____

Do you need food? Yes ___ No ___ Do you need clothing? Yes ___ No ___ Revised 12/2/2011