CLIENT ASSESSMENT FORM

We request this information so that we may learn more about you and are better able to serve your needs; however, if there are any questions that you do not wish to answer, or feel uncomfortable answering, you are not obligated to do so. You may also wish to discuss some information with the client specialist, verbally, during your appointment.

Client Information:

Name:______________________________ Date:__________________

Address: ____

City:____________________________ State:___ Zip:______________

Email address:____

Home Phone: ( )________________ Cell Phone: ( )__________________

Date of Birth:____________________ Age:_____________

Social Security#: ________________ Gender: ___M ___F _Prefer not to answer

Emergency Contact: ____________________ ***Phone:*** *( )*__________________

Email Address: ____

How did you hear about The Pantry of Broward?

☐ Agency referral ☐ Medical/Doctor ☐ 211 ☐ Online

☐ TV/Radio/Newspaper ☐ Other:______________________

Client Race:

☐ Asian ☐ Black/African American ☐ Caucasian (White) ☐ Hispanic ☐ Metis (Mixed)

Ethnicity (Please circle one):

African, Black, African American	***Haitian***	***Asian and African American***	***African Caucasian***
Jamaican	***African Hispanic***	***Hispanic Origin, Latino***	***Asian Hispanic***
Asian Pacific Islander	***Asian American***	***Indo European***	***Israeli***
American Indian, Native American	***Eskimo, Aleut***	***Korean***	***Russian***
White, Caucasian	***Iranian***	***Middle Eastern***	***Unknown***

Have you or anyone in your household been incarcerated in the past 3 years? ☐Yes ☐No

Please clarify any significant legal or criminal history:

____

____

Support System: *List all social and family sources of support.*
(Example: relatives, church,support group, etc.)

Name	Address	Phone number

How are you doing in your family relationships?

☐ N/ A ☐ Cannot Function ☐ Serious Problems

☐ Moderate Problems ☐ Mild Problems ☐ No Problems

Current Household Members:

Name	Relation to self	Date of Birth	Age	Gender	Attending school?		Name of school and grade level
					Y	N	
					Y	N	
					Y	N	
					Y	N	
					Y	N	
					Y	N	
					Y	N	

Employment Status:

☐ Employed ☐ Self Employed ☐ Unemployed ☐ Retired

☐ Retired Veteran or Veteran's spouse ☐ Disabled

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse/Significant Other:

Name:____Cell Phone: ( )______________

Date of Birth:______________Age: ____ Social Security Number: _____-____-_____

Please select Spouse/Significant Other Race/Ethnicity:

☐Asian ☐Black/ African American ☐American Indian ☐Caucasian

☐Haitian ☐Hispanic/Latin ☐ Jamaican ☐Russian

☐ Middle Eastern ☐Pacific Islander ☐Other: __________________

Is your spouse/significant other currently employed? ☐ Yes☐ No

If yes, complete the following:

Occupation:____________________Employed by:__________________________

☐Full time ☐Part time ☐Per Diem ☐Other:_____________________________

Level of Education:

School level completed (Circle highest year completed):

1 2 3 4 5 6 7 8 9 10 11 12

College: 1 2 3 4 (Circle highest year completed); Degree obtained: ☐Yes☐ No

Graduate School: ☐ Yes☐ No Degree obtained: ☐ Yes☐ No

Degree(s) awarded:____

Do you have a computer in your home?

☐ Yes ☐ No

If no, do you have access to one? ☐ Yes ☐ No

Where do you have access to a computer?_________________________________

Do you have internet access? ☐ Yes ☐No

How would you rate your current physical health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you under the care of a physician? ☐ Yes ☐ No

If yes, provide name and phone number of Physician:

____

When was your last complete physical examination?__________________________

Do you exercise? ☐Yes ☐No

If yes, how often?____

Please list exercise(s):____

Have you or any members in your household been declared disabled by the Department of Disability? ☐Yes ☐No

If you answered yes, please provide name and relation to you:

____

Please indicate if you have *(or have had)* any of the following conditions or anything you feel we should know:

☐ Diabetes ☐ High Blood Pressure ☐ Asthma ☐ COPD ☐ High Cholesterol ☐ Cancer

☐Other: ____________________

In the last 3 months, how many times have you been to the ER?

☐ Never ☐ Once ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times

In the last 3 months, how many times have you attended Urgent Care?

☐ Never ☐ Once ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times

Do you smoke cigarettes? ☐Yes ☐No

If Yes, how many a day?____________________________

Please rate your general happiness and well-being:

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9

Very poor Excellent

The following question is optional:

Please note, this question is strictly for statistical internal use to help us identify additional resources and will not be used in any way to determine your eligibility.

Denomination:

☐ 7th Day Adventist ☐ Baptist ☐ Catholic ☐ Methodist ☐ Lutheran

☐ Jehovah's Witness ☐ Wiccan ☐ Muslim ☐ Mormon ☐ Presbyterian

☐ Jewish ☐ Other ____________________

☐ Rather not answer

Church Affiliation: ____

Pastor/Priest/Rabbi/Elder: ____

Do you or any member of your household receive any of the following benefits?

Program	Who's the Beneficiary	Amount	How Often?
SNAP Food Stamps			
Cash Assistance			
SSA/SSI			
WIC			
Pension			
Disability			
Veteran Benefits			
Child Support			
Medicaid/ Medicare			
Unemployment			
Alimony or Veteran's Spouse Benefits			
Cash settlement			
TANF (Temporary Assistance for Needy Families)			

Do you have a Bank account? ☐Yes ☐No

☐Checking ☐Saving ☐Both

Are you receiving benefits from any of the below food assistance programs?

☐ Farmer's Market Coupons ☐ Meals-on-Wheels ☐ ADRC Congregate Meals

☐ Free & Reduced School Lunch

How far is the nearest full-service grocery store to your home?

____

Do you have regular or reliable transportation? ☐Yes ☐No

Have you had to skip a meal in the last month due to lack of resources? ☐Yes ☐ No

Checklist of Concerns:

Please mark all the items below that apply:

☐ Abuse, physical, sexual, emotional, neglect (of children or elderly persons)
☐ Alcohol and/or drug abuse
☐ Career concerns, goals, and choices
☐ Codependence
☐ Confusion
☐ Custody of children
☐ Decision making, putting off decision
☐ Dependence
☐ Depression, low mood, sadness, crying or mourning
☐ Divorce, separation
☐ Eating problem (diet issues)
☐ Fatigue, tiredness, low energy
☐ Financial or money troubles (debt, impulsive spending and gambling, low income}
☐ Health, illness, medical concerns, physical problems, pain, chronic
☐ Housework/chores, hoarding, environmental hygiene and safety
☐ Legal matters, charges, suits
☐ Literacy
☐ Loneliness
☐ Marital conflict
☐ Panic, anxiety attacks
☐ Parenting, child management, single parenthood
☐ Relationship problems (with friends, relatives, or at work)
☐ School problems
☐ Spiritual, religious, moral, ethical issues
☐ Stress, stress management, stress disorder, suicidal thoughts
☐ Weight and diet issues
☐ Withdrawal, isolating

In the event that my application is accepted, I am willing to be contacted by The Pantry of Broward, Inc. staff to be interviewed or photographed for various media promotions (newsletter, radio, television, Facebook, etc.). This may include filming or interviewing any minor children that live in the household.

☐Yes **(If yes, please sign below)** ☐No **(Do not sign)**

Print Client Name	Client Signature	Date
Print Witness Name	Witness Signature	Date

<u>All applicants must sign:</u>
By signing this form, I agree that all information supplied by me, is true and complete to the best of my knowledge and belief.

Print Client Name or Legal Guardian	Client Signature or Legal Guardian	Date
Print Witness Name	Witness Signature	Date

Monthly Income and Expenses

Use this worksheet to list monthly income and expenses.

Family Name: ______________________________ Date form Completed: _____________

BASIC LIVING EXPENSES

MONTHLY EXPENSE	AMOUNT
Rent/Mortgage/HOA	$
Electricity/Gas	$
Water/Sewer	$
Cable/Satellite	$
Internet	$
Cell Phone/Landline	$
Car Payment	$
Car insurance payment	$
Groceries	$
Doctor co-pays	$
Prescriptions	$
Health/Life insurance	$
Home owner insurance	$
Other	
MONTHLY EXPENSES (total from above)	**$**

Please report monthly income using the section below.

TAKE HOME INCOME/PAYCHECKS/STATE BENEFITS

(After taxes and benefits are taken out)

Income (1) $ ___________

Income (2) $ ___________

Income (3) $ ___________

Food Stamps $___________

TOTAL MONTHLY NET (TAKE HOME) INCOME $ ______________

Office use only

Minus Total Monthly Expenses - ____________

Difference +/- ___________

Revised 09/2019

FEEDING SOUTH FLORIDA

EMERGENCY FOOD ASSISTANCE PROGRAM (TEFAP)
CERTIFICATION OF ELIGIBILITY TO TAKE FOOD HOME
7 CFR 251

Name: ______________________________ Number of People In Household: __________
Address: ______________________________
______________________________ County: ______________________________

The following shows a yearly gross income for each family size. If your household income is at or below the income listed for the number of people in your household, you are eligible to receive food. **The chart below is effective July 1, 2022 - June 30, 2023.**

Household Size	Annual Income	Monthly Income	Twice per Month	Every two Weeks	Weekly Income
1	$17,667	$1,473	$737	$680	$340
2	$23,803	$1,984	$992	$916	$458
3	$29,939	$2,495	$1,248	$1,152	$576
4	$36,075	$3,007	$1,504	$1,388	$694
5	$42,211	$3,518	$1,759	$1,624	$812
6	$48,347	$4,029	$2,015	$1,860	$930
7	$54,483	$4,541	$2,271	$2,096	$1,048
8	$60,619	$5,052	$2,526	$2,332	$1,166
For each additional family member add:	$6,136	$512	$256	$236	$118

The chart details eligibility criteria for monthly income, income received twice monthly (24 payments per year), income received every two weeks (26 payments per year) and weekly income.

You are eligible to receive food from TEFAP if your household meets the income guidelines above or participates in any of the following programs. Please place a checkmark in the space next to the category that applies.

_______Income eligibility
_______Supplemental Nutrition Assistance Program (SNAP) (aka Food Stamps)
_______Temporary Assistance to Needy Families (TANF)
_______Supplemental Security Income (SSI)
_______Medicaid

Please read the following statement carefully and then sign the form and write in today's date. You only need to meet one of these requirements to be eligible to receive USDA foods.

I certify that my yearly household gross income is at or below the income listed on this form for households with the same number of people ***OR*** *that I participate in the program(s) that I have checked on this form. I also certify that as of today, I reside in the State of Florida. This certification is being submitted in connection with the receipt of Federal assistance. Program officials may verify what I have certified to be true. I understand that making a false certification may result in having to pay the State agency for the value of the food improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law.*

Signature: ______________________________ Date: __________

Designated Individual signing on behalf of client or designated proxy
Signature: ______________________________ Date: __________

THIS CERTIFICATION IS VALID FOR A PERIOD OF ONE YEAR and may be renewed as needed. Any changes in the household's circumstances must be reported to the distributing agency immediately.

OPTIONAL: I authorize ______________________________ to pick up USDA foods on my behalf.