

NEEDS/EXPENSE ASSESSMENT

DATE: _____ LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____
 APPLICANT SOCIAL SECURITY # _____ DATE OF BIRTH: _____ AGE: _____
 ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ PHONE: _____
 SEX: M or F MARITAL STATUS: Married; Single; Div; Wid. RACE: White, Black; Hispanic, Asian; Other _____
 LAST/CURRENT EMPLOYER: _____ CAR MAKE: _____ YEAR: _____
 FAMILY SIZE: #Male Adults _____ #Female Adults _____ #Children _____ Guardian _____ #Foster _____ TOTAL _____

HOUSEHOLD MEMBERS: (Please list all household member below. Indicate "none" if applicable)

<u>NAME</u>	<u>RACE</u>	<u>SEX</u>	<u>DATE OF BIRTH</u>	<u>RELATION</u>	<u>SOCIAL SECURITY:</u>
					XXX-XX-
					XXX-XX-
					XXX-XX-
					XXX-XX-
					XXX-XX-

Briefly describe the crisis that cause you to apply for emergency assistance: _____

MONTHLY HOUSEHOLD INCOME	DOLLARS	MONTHLY EXPENSE	DOLLARS
SOCIAL SECURITY		RENT	
CHILD SUPPORT		UTILITIES	
SSI/SSDI		MEDICAL BILLS	
FOOD STAMPS		INSURANCE	
OTHER			
TOTALS		TOTALS	

Are you willing to do volunteer work? Yes No

RELEASE OF INFORMATION: I HEREBY AUTHORIZE "THE CHURCH" PARISH NURSE MINISTRIES, INC. TO REQUEST AND RELEASE ANY AND ALL INFORMATION NECESSARY TO FACILITATE AND PROVIDE SERVICES. I UNDERSTAND THAT KNOWINGLY GIVING FALSE AND/OR INCOMPLETE INFORMATION COULD RESULT IN ME AND ALL MEMBERS OF MY HOUSEHOLD BEING DISQUALIFIED FOR SERVICES PROVIDED BY "THE CHURCH" PARISH NURSE MINISTRIES, INC., AND WILL BE DEALT WITH ACCORDINGLY.
I CERTIFY THE INFORMATION PROVIDED ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I CAN ONLY REGISTER FAMILY MEMBERS LIVING IN MY HOUSE ON A FULL-TIME BASIS AND DOES NOT INCLUDE VISITORS.

SIGNATURE OF APPLICANT: _____ REVIEWER SIGNATURE _____

ASSISTANCE GIVEN
 FINANCIAL: TYPE _____ AMOUNT\$ _____ DATE _____ CK# _____ Referred /Not Referred