

# PARTNERSHIP FOR COMMUNITY ACTION

## Applicant Information

*Complete for individuals who are applying to a program.*

Primary Adult Name \_\_\_\_\_ Birthday \_\_\_\_\_

General									
<b>Family Member:</b> <input type="checkbox"/> Adult <input type="checkbox"/> Child			<b>If Adult:</b> <input type="checkbox"/> Primary Adult <input type="checkbox"/> Secondary Adult <input type="checkbox"/> Third/Other Adult						
<b>Last</b>		<b>First</b>			<b>Middle</b>		<b>Preferred</b>		<b>Suffix</b>
<b>Birthday</b>			<b>SSN</b>				<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		
Complete if Family Member is a Child					Complete if Family Member is an Adult				
<b>Adult Name</b>		<b>Child's Relationship</b>		<b>Custody?</b>	<b>Lives w/ Family?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Provides Financial Support?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
Releases Signed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Signed			<b>Education Level Code</b>		<b>Employment Status Code</b>		
<b>CACFP Status</b>	<b>CACFP Date</b>		<b>CACFP Income</b>		<b>Teen Parent?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Subsidized?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
Address/Phone - Complete ONLY information that is different than Family									
<b>Living Address</b>					<b>Mailing Address</b>				
<b>Living Address Line 2</b>					<b>Mailing Address Line 2</b>				
<b>City</b>		<b>State</b>	<b>Zip</b>	<b>County</b>	<b>City</b>		<b>State</b>	<b>Zip</b>	
<b>Type</b>	<b>Primary</b>	<b>Phone Number</b>			<b>Note</b>	<i>Note: Fill in Email and Elementary School for ALL individuals where applicable</i>			
	<input type="checkbox"/>					<b>Email</b>			
					<b>Elementary School</b>				
Health Coverage									
<b>Medicaid Eligibility Status:</b> <input type="checkbox"/> Eligible <input type="checkbox"/> Not <input type="checkbox"/> Potentially						<b>Medicaid Number</b>			
<b>Primary Health Coverage</b>						<b>Insurance Number</b>			
<b>Other Health Coverage</b>									
Demographics									
<b>Race (check ALL that apply):</b>				<b>Language</b>		<b>Primary</b>	<b>Proficiency</b>	<b>Nationality</b>	
<input type="checkbox"/> Asian	<input type="checkbox"/> Native American			English		<input type="checkbox"/>		_____	
<input type="checkbox"/> Black	<input type="checkbox"/> Pacific Islander					<input type="checkbox"/>		<b>Ethnicity</b>	
<input type="checkbox"/> White	<input type="checkbox"/> Other	_____				<input type="checkbox"/>		_____	
Codes									
<b>Child's Relationship</b>		<b>Education Level</b>			<b>Employment Status</b>		<b>Phone Type</b>		<b>Language Proficiency</b>
C-Natural/Adopted/Step		COL-College/Advanced Training	G9-Grade 9 or less		F-Full Time(35+hrs/wk)	B-Full Time & Training	H-Home	W-Work	0-None
G-Grandchild		CTG-College Degree/Training Cert	G10-Grade 10		P-Part Time Training	L-Part Time & Training	C-Cell		1-Poor
N-Niece/Nephew		HSG-High School Grad	G11-Grade 11		R-Retired or Disabled	S-Seasonally Employed	M-Message		2-Moderate
F-Foster O-Other		GED-General Education Diploma	G12-Grade 12		T-Training or School	U-Unemployed	P-Pager/Beeper		3-Proficient
		A-Associate's Degree	B-Bachelor's Degree						
		M-Master's Degree							

*Certification: I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subjected to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.*

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Verifying Staff Member \_\_\_\_\_ Date \_\_\_\_\_

## PARTNERSHIP FOR COMMUNITY ACTION

### Family Information

*Shaded boxes will be completed by agency staff*

ChildPlus Family ID # \_\_\_\_\_

Primary Adult Name \_\_\_\_\_ SSN \_\_\_\_\_ Birthday \_\_\_\_\_

Address								
Living Address								
Living Address Line 2								
City		State		Zip		County		
Mailing Address (if different)								
Mailing Address Line 2								
City		State		Zip				
Phone Numbers								
Type	Primary	Phone Number			Note			
	<input type="checkbox"/>							
Phone Type Codes: H-Home    W-Work    C-Cell    M-Message    P-Pager/Beeper								
General								
Primary Site			Parental Status: <input type="checkbox"/> One <input type="checkbox"/> Two		Primary Language at Home:			
Number in Family _____		Number of Children _____		By age: 0-3 _____ 4-5 _____		Number in Household _____		
Income Support								
CACFP Status: <input type="checkbox"/> Full <input type="checkbox"/> Reduced <input type="checkbox"/> No or Little			CACFP Date		CACFP Income			
TANF Status: <input type="checkbox"/> Yes <input type="checkbox"/> No		SSI: <input type="checkbox"/> Yes <input type="checkbox"/> No		WIC: <input type="checkbox"/> Yes <input type="checkbox"/> No		WIC Code		
Family Income								
Family Member	Date	Source	Amount	Per	Annual Amount	Type	Desc	Verification
Type Codes		Description Codes		Verification Codes				
ERN - Earned		PEN - Pension		CS - Check Stub		W2 - W-2		
SUB - Subsidized		SS - Social Security		EL - Employer Letter		TAN - TANF		
Income Notes								

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Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Verifying Staff Member \_\_\_\_\_

Date \_\_\_\_\_

## PARTNERSHIP FOR COMMUNITY ACTION

### Family Member Information

Complete for each non-applicant family member.

Primary Adult Name \_\_\_\_\_ Birthday \_\_\_\_\_

<b>FAMILY MEMBER 1</b>					
<b>General</b>					
<b>Family Member:</b> <input checked="" type="checkbox"/> Adult <input type="checkbox"/> Child		<b>If Adult:</b> <input type="checkbox"/> Primary Adult <input type="checkbox"/> Secondary Adult <input type="checkbox"/> Third/Other Adult			
<b>Last</b>	<b>First</b>	<b>Middle</b>	<b>Preferred</b>	<b>Suffix</b>	
<b>Birthday</b>	<b>SSN</b>		<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		
<b>Complete if Family Member is a Child</b>			<b>Complete if Family Member is an Adult</b>		
<b>Adult Name</b>	<b>Child's Relationship</b>	<b>Custody?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Lives w/ Family?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Provides Financial Support?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Highest grade completed</b>	<b>Present Employment Status</b>
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Teen Parent?</b>	<b>Subsidized?</b>
<b>Releases Signed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Date Signed</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Notes</b>					

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Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Verifying Staff Member \_\_\_\_\_ Date \_\_\_\_\_

## PARTNERSHIP FOR COMMUNITY ACTION Contacts

Primary Adult Name \_\_\_\_\_ Birthday \_\_\_\_\_ SSN \_\_\_\_\_

Family Contacts						
<b>Contact 1</b>	Name		Phone Type	Phone Number	Phone Note	Relationship
	Address					
	Address Line 2					Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
	City					
	State	Zip				
		Release To? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Family Doctor						
Doctor Name		Address		City	State	Zip
						Phone
Family Dentist						
Dentist Name		Address		City	State	Zip
						Phone

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Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Verifying Staff Member \_\_\_\_\_

Date \_\_\_\_\_