

# Houston Food Bank Partner Agency Pantry Family Intake Form B

## HELPING HANDS OF ROSHARON

Please answer all questions so that we may serve you better. This information will not be shared with any other outside agency or entity others than the Houston Food Bank for reporting purposes.

website: <https://helpinghandsofrosh.wixsite.com/mysite-1>

**CLIENT DOCUMENTATION (client may fill this out)** **Date of Intake:** \_\_\_\_\_  
Are you homeless? ☐ Yes ☐ No If no, please complete address portion of form.

### Household Information:

<b>YOUR NAME</b>	
<b>ADDRESS</b>	
<b>CITY / STATE / ZIP / COUNTY</b>	
<b>PHONE</b>	

How many people live in your house: Are  you head of the household? 

Yes	No
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### Are you?

African American		Asian		Caucasian		Hispanic		Native American		Other	
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How many people live in your house in the following age / gender groups: (please write the number in the box?)

Infant-17		18-64 yrs		65 and over	
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Does your family receive any type of assistance? *Check all that apply*

Temporary Assistance To Needy Families (TANF / AFDC)		SNAP (Food Stamps)	
SSI		Medicaid	
CHIP		WIC	

The Total Gross Income (the amount before deductions) of all household members is:

GROSS INCOME	\$			Per Year		Per Month		Per Week	
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Was there an emergency situation that caused you to need food?

Yes	No
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If yes, please state situation	
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**Client Signature (client must be present for initial interview and food assistance)**

**Date**

*I certify that I am a member of the household listed above and that on behalf of this household I have applied for USDA Products. I certify that all information regarding my household is true to the best of my knowledge. I also designate the following person as an authorized representative of my household and certify that their information is correct to the best of my knowledge. Authorized representative is able to pick up product for client until re-certification is necessary...*

Name of Authorized Representative: (not name of family member only person to act on their behalf)	Authorized Representatives Address:
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## AGENCY DOCUMENTATION ( FOR STAFF ONLY )

Family Name: \_\_\_\_\_ Date: \_\_\_\_\_

☐ **Household is INELIGIBLE:** (clients denied USDA products should be referred to the HFB for review)

☐ Income level over 185% listed on Annual Income Guidelines

☐ Is not an emergency situation and does not meet any other criteria

☐ Other: \_\_\_\_\_

☐ **Household is ELIGIBLE based on:**

☐ **Low Income** (Enter certification period below; sign and date the form at the bottom)

☐ **Emergency Food Need** (Describe emergency need in "Comments" section; enter "Certification Period;" sign and date the form, clients in this category may be served no more than 6 months unless another emergency can be documented.)

☐ **Receipt of TANF/AFDC** (Enter the "Certification Period;" sign and date the form.)

☐ **Receipt of Food Stamps** (Enter "Certification Period;" sign and date the form.)

☐ **Receipt of SSI** (Enter the "Certification Period;" sign and date the form.)

☐ **Receipt of Medicaid** (Enter the "Certification Period;" sign and date the form.)

**Certification Period:** Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**Comments:**

Agency Staff Initials: \_\_\_\_\_

Revisit this form on: \_\_\_\_\_

**Please have client sign every time they come receive assistance  
(if you have another form for this that is fine, but you must keep all documentation accessible and together)**

Date	Signature of Client (by client)

	<b>FAMILY MEMBERS IN HOUSEHOLD</b>
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NAME	DATE OF BIRTH	AGE	RELATIONSHIP

Please Note: If you fill application out on our website. Please send it in to the email of [helpinghandsofrosharon@gmail.com](mailto:helpinghandsofrosharon@gmail.com) and our Pantry Director will email to let you that your application has been recieved, also please bring in the following documents that are needed.

Thanks in Advance,  
Staff