



Food Bank Pantry

Family / Individual Intake Form

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 San Antonio Food Bank for reporting purposes.

CLIENT DOCUMENTATION (client may fill this out) **Date of Intake:** _____

Household Information

Are you homeless? **Yes** **No** If no, please complete address portion of form.

YOUR NAME	
ADDRESS	
CITY / STATE/ ZIP/ COUNTY	
PHONE	

Are you? African American Asian Caucasian Hispanic Native American Other

How many people live in your house: _____

Are you the head of household ? Yes No **Are you?** Male Female

How many people live in your house in the following age / gender groups: (please write the number in the box)

0-5 yrs		6-18 yrs		19-40 yrs		41-59 yrs		60 and over	
# Males in house					# Females in house				

Are there any **veterans** residing in your household? Yes No If yes, how many? _____

Is there someone in your home that has a **disability**? Yes No

If yes, how many fall into the following categories:

	Physical Disability		Mental Disability
	Abuse or Neglect		Other :
			Chronic Illness (includes sub abuse)
			Other :

Does your family receive any type of assistance? Yes No **If yes check those that apply**

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

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

\$ _____ Per Year Per Month Per Week

Was there an emergency situation that caused you to need food? Yes No

If yes, please state situation _____

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.

Name of Authorized Representative <small>(not name of family member only person to act on their behalf)</small>	Authorized Representatives Address
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AGENCY DOCUMENTATION

Family Name: _____ Date: _____

- Household is INELIGIBLE:** (clients denied USDA products should be referred to the SAFB for review)
 - Income level over 185% listed on 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.)
 - 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: _____
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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)