Healthy Communities Coalition

Lyon County Food Bank

Household Intake Form

PLEASE PRINT CLEARLY

Program Year: _____-_____ Date: _____

Declaration of Income: ☐ Verified by: _____

Verification of Residency: ☐ Verified by: _____

Release of Information: ☐ Verified by: _____

HEAD OF HOUSEHOLD

Name: _____ Sex: ____ Date of Birth: _____Age: _____ Vet: ___
Last Middle First

Phone: _____Email: _____Last four of SSN:_____

Physical Address: _____
(Street, City, State, ZIP)

Mailing Address: _____
(Street, City, State, ZIP)

ADDITIONAL HOUSEHOLD MEMBERS*

Name (First, Last)	APU	Sex	Relationship	Date of Birth	Age	Vet
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						

*Adult non-members that are authorized to pick up for the household must be added by the Head of Household.

Total household members: _____ By Sex: Males _____ Females _____ Other _____ Unknown _____ Declined _____

By age group: 0-12 _____ 13-17 _____ 18-64 _____ 65+ _____ Unknown _____ Declined _____

By Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino _____ Unknown _____ Declined _____

By Race: American Indian or Alaska Native _____ Asian _____ Black or African American _____ White _____

Native Hawaiian or Pacific Islander _____ Multi-Racial _____ Other _____ Unknown _____ Declined _____

County of residence: _____ Duration: ☐ Less than 1 month ☐ 1 to 24 months ☐ More than 24 months

Program Year: _____ - _____

YEARLY HOUSEHOLD INCOME

Please indicate yearly household income. First, find the column with the number of household members. Then, mark an X across the box under that column where the income level matches your household. **EXAMPLE**: A household with 5 members, without an income, would mark an X across the box below column 5 labeled $30,170 or less.

Number of Household Members

Income Level	1	2	3	4	5	6	7	8 or more
Low	$24,980 or less	$33,820 or less	$42,660 or less	$51,500 or less	$60,340 or less	$69,180 or less	$78,020 or less	$86,860 or less
Very Low	$18,735 or less	$25,365 or less	$31,995 or less	$38,625 or less	$45,255 or less	$51,885 or less	$58,515 or less	$65,145 or less
Extremely Low	$12,490 or less	$16,910 or less	$21,330 or less	$25,750 or less	$30,170 or less	$34,590 or less	$39,010 or less	$43,430 or less

HEALTH SURVEY

Do you have a primary care provider? ☐ Yes ☐ No ☐ Declined

If yes, have you seen your primary care provider in the past 12 months? ☐ Yes ☐ No ☐ Declined

If no, would you like help finding a primary health care provider? ☐ Yes ☐ No ☐ Declined

What is your insurance status (check all that apply)? ☐ Self-Pay ☐ Uninsured ☐ Medicare only ☐ Medicaid & Medicare

☐ Medicaid only ☐ Nevada Check Up ☐ Medicare plus supplemental ☐ Other third party ☐ Declined

NON-DISCRIMINATION STATEMENT

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Program Year: _____ - _____

Consent for Data Collection and Release of Information

Participation in data collection and authorization for release of information, although optional, is a critical component of our organization's ability to provide the most effective services possible.

This client Notice and Consent describes how information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. If you have any questions or desire any further information regarding this form, please contact *Healthy Communities Coalition* at (775) 246-7550.

The information that is collected is protected by limiting access to the data and by limiting with whom the information may be shared, in compliance with the standards set forth by federal, state, and local regulations governing confidentiality of client records. Every person and agency that is authorized to collect or review the data has signed an agreement to maintain the security and confidentiality of the information. Any person or agency that is found to violate their agreement may have their access rights terminated and may be subject to further penalties.

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:
I authorize the partner agencies and their representatives to share basic information regarding my household and me. I understand that this information is for assessing our needs for housing, utility assistance, food, counseling, and/or other services.

The information may consist of the following PPI (Protected Personal Information):

- ❖ Identifying Information (Name, birth date, gender, ethnicity and race, social security number, residential information, phone number, photograph likeness, etc., and the same for each household member)
- ❖ Financial Information (employment status, income verification, public assistance payments and allowances, food stamp allotments, etc.)

I UNDERSTAND THAT:

- Information I give concerning physical or mental health problems may be shared with other partner agencies in a way that identifies me.
- The partner agencies have signed agreements to treat my information in a professional and confidential manner. I have the right to view the client confidentiality policies used by the Partner Agencies.
- Staff members of the partner agencies who will see my information have signed agreements to maintain confidentiality regarding my information.
- The release of my information does not guarantee that I will receive assistance, and my refusal to authorize the use of my information does not disqualify me from receiving assistance.
- This authorization will remain in effect until I revoke it in writing, and I may revoke authorization by signing a Client Revocation of Consent to Release Information form. If not previously revoked, this consent terminates automatically 5 years from today.
- If I revoke my authorization, all information about me already collected will remain, but will become inaccessible to all the partner agencies.
- My records are protected by federal, state, and local regulations governing confidentiality of client records and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- People may use this information to write reports and may see your information. Researchers must sign an agreement to protect your privacy before seeing the data. Your private information will never appear in research reports.
- I understand that participation in data collection is optional, and I may choose not to participate.

Name (Please Print)	Signature	Date
Address	City, State	ZIP
Authorized HCC Representative	Signature	Date

Program Year: _____ - _____

Sign-In

July	T	August	T	September	T
1: _____	☐	1: _____	☐	1: _____	☐
2: _____	☐	2: _____	☐	2: _____	☐
3: _____	☐	3: _____	☐	3: _____	☐
4: _____	☐	4: _____	☐	4: _____	☐
5: _____	☐	5: _____	☐	5: _____	☐
October	**T**	**November**	**T**	**December**	**T**
1: _____	☐	1: _____	☐	1: _____	☐
2: _____	☐	2: _____	☐	2: _____	☐
3: _____	☐	3: _____	☐	3: _____	☐
4: _____	☐	4: _____	☐	4: _____	☐
5: _____	☐	5: _____	☐	5: _____	☐
January	**T**	**February**	**T**	**March**	**T**
1: _____	☐	1: _____	☐	1: _____	☐
2: _____	☐	2: _____	☐	2: _____	☐
3: _____	☐	3: _____	☐	3: _____	☐
4: _____	☐	4: _____	☐	4: _____	☐
5: _____	☐	5: _____	☐	5: _____	☐
April	**T**	**May**	**T**	**June**	**T**
1: _____	☐	1: _____	☐	1: _____	☐
2: _____	☐	2: _____	☐	2: _____	☐
3: _____	☐	3: _____	☐	3: _____	☐
4: _____	☐	4: _____	☐	4: _____	☐
5: _____	☐	5: _____	☐	5: _____	☐

Households are entitled to receive food assistance once per week.