Pahrump Office
Marilynn Gallivan Complex
1981 E. Calvada Blvd. North
Suite 120
Pahrump, NV 89048
Phone: (775) 751-7095
Fax: (775) 751-4284

Health and Human Services
Director - Karyn Smith

Tonopah Office
Nye County Courthouse
101 Radar Road
Post Office Box 926
Tonopah, NV 89049
Phone: (775) 482-8125
Fax: (775) 482-7261

APPLICATION FOR ASSISTANCE

A. TYPE OF ASSISTANCE REQUESTED:

☐ Food ☐ Employment Incentive ☐ Dental ☐ Rent (first or last mo.) $_____ # Bedrooms: _____
☐ Transportation ☐ Child Care ☐ Prescriptions ☐ Deposit (Rent/Electric/Water/Propane) $_____
☐ Utilities $_____ ☐ Burial/Cremation ☐ Ryan White - EFA ☐ Other: _____

B1. APPLICANT/HOUSEHOLD INFORMATION: (please print clearly)

For Office Use Only	Household Member Name Last, First, Middle Initial	Relationship TO Head of Household	Marital Status *See Below*	Gender Identity *See Below*	Sexual Orient. *See Below*	Age	Date of Birth	Social Security Number	Disabled Y/N	Veteran Y/N	US Citizen Y/N	Ethnicity *See Below*	Race *See Below*
		SELF											

Are there additional people in your home not listed here? (check one) ☐ Yes ☐ No **If "YES," please ask a staff member for an additional household member information sheet.**

***Marital Status:** **S** - Single **M** - Married **D** - Divorced **IR** - In Relationship **CU** - Civil Union **CL** - Common Law **W** - Widowed **Sep** - Separated
***Gender Idenity:** **F** - Female **M** - Male **MTF** - Trans Female (Male to Female) **FTM** - Trans Male (Female to Male) **GNC** - Gender Non-Conforming **O** - Other **X** - Refused
***Sexual Orientation:** **H** - Heterosexual **G** - Gay **L** - Lesbian **B** - Bisexual **Q** - Questioning/Unsure **O** - Other **X** - Refused
***Ethinicity:** **H** - Hispanic **N** - Non-Hispanic **O** - Other/Unknown
***Race:** **W** - Caucasian/White **AA** - African American/Black **A** - Asian **AI** - American Indian/Alaska Native **PI** - Pacific Islander/Native Hawaiian **MR** - Multi Race (one or more) **O** - Other/Unknown

C. HOUSING INFORMATION:

Home Address: **City:** **State:** **Zip:**

Mailing Address: **City:** **State:** **Zip:**

Primary Phone Number:

Secondary Phone Number:

Email Address:

Length of time at CURRENT residence:
Years: Months: Days:

Have you been a Nevada resident for 2+ years? ☐ Yes ☐ No

How long have you been a resident of Nye County?

Are you currently homeless? ☐ Yes ☐ No
If yes, where did you sleep last night?

Have you ever applied for Section 8?: ☐ Yes ☐ No **If so, when?:** **What City/State?:**

Have you/anyone in your household ever been evicted from subsidized housing?: ☐ Yes ☐ No

Have you been continually homeless for at least one year?: ☐ Yes ☐ No

How many times have you been homeless in the last 3 years?:

How many months continually homeless prior to today?:

D1. ADULT INFORMATION: (Required for each person 18 years or older in household)

1st Adult Household Member's Name:	**2nd Adult Household Member's Name:**
What school grade did you last complete?	**What school grade did you last complete?**
Diploma? ☐ Yes ☐ No **GED?** ☐ Yes ☐ No	**Diploma?** ☐ Yes ☐ No **GED?** ☐ Yes ☐ No
Are you in school or working on a degree? ☐ Yes ☐ No **If yes, what school?**	**Are you in school or working on a degree?** ☐ Yes ☐ No **If yes, what school?**
Work Status: (check one) ☐ Employed Full-Time ☐ Employed Part-Time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (Short-term) ☐ Unemployed (Long-term) ☐ Unemployed (Not in Labor Force) ☐ Retired ☐ Unknown/Not Reported	**Work Status: (check one)** ☐ Employed Full-Time ☐ Employed Part-Time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (Short-term) ☐ Unemployed (Long-term) ☐ Unemployed (Not in Labor Force) ☐ Retired ☐ Unknown/Not Reported
Health Insurance: (check all that apply) ☐ Medicaid ☐ Medicare ☐ Private Health Insurance ☐ Nevada Check-Up ☐ Direct-Purchase ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults ☐ Military Healthcare (VA) ☐ Employment Based ☐ Tribal Insurance ☐ No Health Insurance ☐ Unknown/Not Reported	**Health Insurance: (check all that apply)** ☐ Medicaid ☐ Medicare ☐ Private Health Insurance ☐ Nevada Check-Up ☐ Direct-Purchase ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults ☐ Military Healthcare (VA) ☐ Employment Based ☐ Tribal Insurance ☐ No Health Insurance ☐ Unknown/Not Reported
Check ONE for each category:	**Check ONE for each category:**
Do you have a disabling condition? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have a disabling condition?** ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Do you have a physical disability? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have a physical disability?** ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
-Is it long term? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**-Is it long term?** ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Do you have a developmental disability? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have a developmental disability?** ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Do you have a chronic health condition? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have a chronic health condition?** ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Do you have HIV/AIDS? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have HIV/AIDS?** ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Do you have a mental health problem? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have a mental health problem?** ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Do you have a substance abuse problem? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have a substance abuse problem?** ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Are you a domestic violence victim/survivor? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Are you a domestic violence victim/survivor?** ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Have you been convicted of a misdemeanor or felony? ☐ Yes ☐ No	**Have you been convicted of a misdemeanor or felony?** ☐ Yes ☐ No
Are you required to register? ☐ Yes ☐ No	**Are you required to register?** ☐ Yes ☐ No
Explain conviction and date:	**Explain conviction and date:**
List last 3 years arrests:	**List last 3 years arrests:**

*** If you have more than 2 adults in household, please ask a staff member for an additional adult information sheet.**

E1. CHILD INFORMATION: (Required for each person 17 years or younger in household)

1st Child's Name:	**Grade:**	**2nd Child's Name:**	**Grade:**
Are they attending school? ☐ Yes ☐ No	**If yes, what school?**	**Are they attending school?** ☐ Yes ☐ No	**If yes, what school?**
If NOT enrolled, what was the last date he/she was enrolled?		**If NOT enrolled, what was the last date he/she was enrolled?**	
Health Insurance: (check all that apply) ☐ Medicaid ☐ Medicare ☐ Private Health Insurance ☐ Nevada Check-Up ☐ Direct-Purchase ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults ☐ Military Healthcare (VA) ☐ Employment Based ☐ Tribal Insurance ☐ No Health Insurance ☐ Unknown/Not Reported		**Health Insurance: (check all that apply)** ☐ Medicaid ☐ Medicare ☐ Private Health Insurance ☐ Nevada Check-Up ☐ Direct-Purchase ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults ☐ Military Healthcare (VA) ☐ Employment Based ☐ Tribal Insurance ☐ No Health Insurance ☐ Unknown/Not Reported	
Check ONE for each category:		**Check ONE for each category:**	
Do you have a disabling condition?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have a disabling condition?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Do you have a physical disability?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have a physical disability?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
-Is it long term?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**-Is it long term?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Do you have a developmental disability?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have a developmental disability?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Do you have a chronic health condition?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have a chronic health condition?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Do you have HIV/AIDS?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have HIV/AIDS?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Do you have a mental health problem?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have a mental health problem?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Do you have a substance abuse problem?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have a substance abuse problem?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Are you a domestic violence victim/survivor?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Are you a domestic violence victim/survivor?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

3rd Child's Name:	**Grade:**	**4th Child's Name:**	**Grade:**
Are they attending school? ☐ Yes ☐ No	**If yes, what school?**	**Are they attending school?** ☐ Yes ☐ No	**If yes, what school?**
If NOT enrolled, what was the last date he/she was enrolled?		**If NOT enrolled, what was the last date he/she was enrolled?**	
Health Insurance: (check all that apply) ☐ Medicaid ☐ Medicare ☐ Private Health Insurance ☐ Nevada Check-Up ☐ Direct-Purchase ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults ☐ Military Healthcare (VA) ☐ Employment Based ☐ Tribal Insurance ☐ No Health Insurance ☐ Unknown/Not Reported		**Health Insurance: (check all that apply)** ☐ Medicaid ☐ Medicare ☐ Private Health Insurance ☐ Nevada Check-Up ☐ Direct-Purchase ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults ☐ Military Healthcare (VA) ☐ Employment Based ☐ Tribal Insurance ☐ No Health Insurance ☐ Unknown/Not Reported	
Check ONE for each category:		**Check ONE for each category:**	
Do you have a disabling condition?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have a disabling condition?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Do you have a physical disability?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have a physical disability?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
-Is it long term?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**-Is it long term?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Do you have a developmental disability?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have a developmental disability?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Do you have a chronic health condition?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have a chronic health condition?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Do you have HIV/AIDS?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have HIV/AIDS?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Do you have a mental health problem?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have a mental health problem?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Do you have a substance abuse problem?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Do you have a substance abuse problem?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Are you a domestic violence victim/survivor?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	**Are you a domestic violence victim/survivor?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

*** If you have more than 4 children in household, please ask a staff member for an additional child information sheet.**

F. ASSETS AND RESOURCES:

Do you or anyone in your household have any of the following resources? (Check all that apply)

- ☐ Checking Account (Balance: $_____)
- ☐ Savings Account (Balance: $_____)
- ☐ Cash on Hand (Amount: $_____)
- ☐ Credit Union Account (Balance: $_____)
- ☐ Savings Bonds
- ☐ Stocks/Bonds (Interest: _____)
- ☐ Individual Indian Money Accounts (IIMA)
- ☐ Business Checking Account
- ☐ Trust Funds
- ☐ Vehicle(s): Year/Make/Model _____
- ☐ Individual Retirement Accounts (IRA)
- ☐ Certificates of Deposit (CD)
- ☐ Other Houses, Land or Buildings
- ☐ Land/Mineral Rights
- ☐ Burial Funds
- ☐ Life Insurance Policies
- ☐ Keogh Accounts (401K)
- ☐ Mining Claims

G. MONTHLY EXPENSES: (only fill out which expenses apply - leave blank if not applicable)

Type	Monthly Amount	Your Share	Company Name (To Whom Expense is Paid)	Who Else Pays?	Current on Payments?
Cable/Satellite	$	$			☐ Yes ☐ No
Car Payment	$	$			☐ Yes ☐ No
Credit Cards	$	$			☐ Yes ☐ No
Electricity	$	$			☐ Yes ☐ No
Food	$	$			☐ Yes ☐ No
Garbage/Trash	$	$			☐ Yes ☐ No
Gas/Propane/Wood Heating	$	$			☐ Yes ☐ No
Gasoline Expense	$	$			☐ Yes ☐ No
Insurance	$	$			☐ Yes ☐ No
Internet Access	$	$			☐ Yes ☐ No
Medical Expenses	$	$			☐ Yes ☐ No
Mortgage/Rent	$	$			☐ Yes ☐ No
Space/Lot Rent	$	$			☐ Yes ☐ No
Storage	$	$			☐ Yes ☐ No
Telephone/Cell	$	$			☐ Yes ☐ No
Water/Sewer	$	$			☐ Yes ☐ No
Other	$	$			☐ Yes ☐ No

H. EARNED INCOME:

Please complete the following for all members living in the home that generate income by employment/self-employment:

		Employment Dates			
Household Member	Employer	Begin MM/DD/YY	End MM/DD/YY	Rate of Pay/Frequency	Monthly Income (last 30 days)

I. UNEARNED INCOME: (only fill out which unearned income choices that apply - leave blank if not applicable)

Please complete each item for all members living in home:

Unearned Income	Do you Receive?	Who Receives?	Who's Applied?	Amount	Frequency
Alimony/Spousal Support	☐ Yes ☐ No				
Child Support	☐ Yes ☐ No				
Food Stamps	☐ Yes ☐ No				
Income Grants or Assistance (TANF or Foster Care, etc.)	☐ Yes ☐ No				
Indian General Assistance	☐ Yes ☐ No				
Military Allotment	☐ Yes ☐ No				
Money from Property Rentals/Leases	☐ Yes ☐ No				
Money or Loans from Relatives or Others	☐ Yes ☐ No				
Rent from Boarders/Roomers	☐ Yes ☐ No				
Retirement Pension	☐ Yes ☐ No				
Section 8/HUD Rental Assistance/USDA	☐ Yes ☐ No				
Social Security (Retirement/Survivors)	☐ Yes ☐ No				
Social Security Disability Insurance (SSDI) **See Below	☐ Yes ☐ No				
Supplemental Security Income (SSI) **See Below	☐ Yes ☐ No				
Unemployment Benefits	☐ Yes ☐ No				
Utility Allowance/EAP	☐ Yes ☐ No				
Veterans Benefits - Disability **See Below	☐ Yes ☐ No				
Veterans Benefits - Pension	☐ Yes ☐ No				
Workman's Comp	☐ Yes ☐ No				
Other (please list):	☐ Yes ☐ No				
Non-Banking Income (circle all that apply)					
Payday Loan, pawn, refund anticipation loan, online or yard sales, direct deposit advance, title loan, check-cashing loan, etc.)	☐ Yes ☐ No				

**** If you marked YES to receiving SSDI, SSI or Veterans Benefits - Disability, you MUST mark YES for that individual when it asks if they are disabled on pages 2 and 3.**

J1. VETERANS INFORMATION:

☐ **There are no Veterans in the household** (If there are no Veterans in household, skip to next page)

1st Veteran's Name:	**2nd Veteran's Name:**
Branch of Service	**Branch of Service**
☐ Air Force ☐ Navy ☐ Army ☐ Other ☐ Coast Guard ☐ Unknown/Not Reported ☐ Marines	☐ Air Force ☐ Navy ☐ Army ☐ Other ☐ Coast Guard ☐ Unknown/Not Reported ☐ Marines
Duration of Active Duty (Months): _____	Duration of Active Duty (Months): _____
Served in War Zone:	**Served in War Zone:**
☐ Yes ☐ No ☐ Unknown/Not Reported	☐ Yes ☐ No ☐ Unknown/Not Reported
Duration of War Zone Service (Months): _____	Duration of War Zone Service (Months): _____
Theater/Wars Served In:	**Theater/Wars Served In:**
☐ World War II ☐ Afghanistan ☐ Korean War ☐ Iraq (Iraqi Freedom) ☐ Vietnam War ☐ Iraq (New Dawn) ☐ Persian Gulf War ☐ Other Operations	☐ World War II ☐ Afghanistan ☐ Korean War ☐ Iraq (Iraqi Freedom) ☐ Vietnam War ☐ Iraq (New Dawn) ☐ Persian Gulf War ☐ Other Operations
Discharge Status	**Discharge Status**
☐ Honorable ☐ General under Honorable Conditions ☐ Under other than Honorable Conditions (OTH) ☐ Bad Conduct ☐ Dishonorable ☐ Uncharacterized ☐ Client doesn't know ☐ Client refused	☐ Honorable ☐ General under Honorable Conditions ☐ Under other than Honorable Conditions (OTH) ☐ Bad Conduct ☐ Dishonorable ☐ Uncharacterized ☐ Client doesn't know ☐ Client refused

*** If you have more than 2 Veterans in household, please ask a staff member for an additional Veterans information sheet.**

Please use the space below to explain the reason why you are requesting services. Be specific as to the reasons and/or situation that caused you to be in a crisis situation:

If Nye County Health & Human Services is able to assist you, please use the space below to explain how you will be able to maintain self-sufficiency after assistance is rendered. Please be specific as to resources and steps you will take to avoid crisis in the future:

For Office Use ONLY* - RW EFA apps only - Please list programs you attempted to receive assistance for client and write in reason they were not eligible.

WSA: **AHTF:** **ESG:** **CSBG:**

To the best of my knowledge and under penalty of perjury, I declare that all information provided herein and any other information requested and given is true and correct.

_____
CLIENT'S NAME (please print)

_____ _____
CLIENT'S SIGNATURE **DATE**

_____ _____
WORKER'S SIGNATURE **DATE**

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Authorization for Release of Information

Consent - I authorize and direct any federal, state and/or local agency, organization, business and individuals to release to Nye County Health and Human Services or representatives any information or material to complete or verify my applications for participation, and or to maintain my continued assistance under any county program. I authorize Nye County Health and Human Services to communicate, obtain or release any information necessary from the agencies, business or individuals to continue my case. The purpose of the release is to verify the above information or enhance effective case management. This authorization constitutes a full and complete release from any liability.

Information Covered - I understand that, depending on the program and requirements, previous or requested, including but not limited to:

Residency	Background
Income	Welfare Benefits
Family Status	Medical Records

Groups and Individuals that May be Asked - The groups or individuals that may be asked to release the above information (depending on program requirements) includes, but not limit to:

Previous/Current Landlords	Schools and Colleges	Law Enforcement	Alimony and Child Support Providers
Public Housing Authorities (Section 8, USDA, etc.)	Division of Child and Family Services	Utility Companies	Behavioral and Substance Abuse Treatment
Past and Present Employers	Courts and Post Offices	Medical and Prescription Providers	State Unemployment Agencies
NyE Communities Coalition	Child Care Providers	State/Federal Grant Providers	Other Social Service Providers
Family Resource Center/No to Abuse	Veterans Administration	Banks and Other Financial Institutions	Other:
Social Security Administration	Retirement Systems	Credit Providers	Other:

Conditions - I agree that a photocopy of this authorization maybe used for the purpose stated above and will expire one year from the date of signature.

Signature:

Head of Household	Print Name	Social Security #	Date
Co-Head of Household	Print Name	Social Security #	Date
Other Adult Household Member	Print Name	Social Security #	Date
Other Adult Household Member	Print Name	Social Security #	Date

Name: _____ Date: _____

Assessment	
COVID-19 Affected (MARK 1 BOX FOR HOUSEHOLD)	
	Individual or household member tested negative, recovered from COVID-19, **no longer needing services**
	Individual or household member tested negative for COVID-19, **not in need of services related to COVID-19**
	Individual or household members have not been impacted, exposed, or tested for COVID-19, are symptom free, **no COVID services needed**
	Individual or household member tested positive for COVID-19. **Refused services related to COVID-19**
	Individual or household member connected to services for COVID-19, pending approval
	Individual or household member impacted by COVID-19. (Includes job loss and/or loss of childcare, etc.)
	Individual or household member exposed to COVID-19. Quarantine required
	Individual or household member tested positive for COVID-19
Basic Needs - Other Than Rent/Mortgage/Utilities (MARK 1 BOX FOR HOUSEHOLD)	
	Not in need of basic necessities
	Situation resolved; no longer in need of basic necessities
	Situation addressed; receives **most** basic necessities
	Situation addressed; receives **some** basic necessities
	Urgent situation; in need of basic necessities; can be scheduled
	Emergent situation; immediate
Early Childhood Education (ECE) or Childcare (MARK 1 BOX FOR HOUSEHOLD)	
	Enrolled in Head Start or ECE
	Enrolled in unsubsidized licensed childcare of choice
	Enrolled in licensed subsidized childcare of choice
	Enrolled in subsidized afterschool program
	Enrolled in licensed subsidized child care; limited choice
	Childcare provided by a family member, friend or unlicensed facility
	Enrolled in Head Start (limited hours/day), need for additional child care
	At risk of losing childcare benefits. (Needs to reapply to continue benefits)
	On waiting list for childcare
	Not enrolled in childcare or in unsafe facility
	Does not have minor children or grandchildren in need of ECE

After School, Before School, or Summer Camp Programs (MARK & PUT INITIALS OF EACH CHILD NEXT TO APPROPRIATE BOX)	
	Attends program on a daily basis
	Attends program 4 days a week
	Attends program 3 days a week
	Attends program less than 3 days a week
	At home or in street without adult supervision
	N/A
Education – Adults/Youth (MARK & PUT INITIALS OF EACH ADULT (18 YEARS AND OLDER) NEXT TO APPROPRIATE BOX)	
	Certificate/license from technical/professional training
	Post-Secondary degree: Associates, Bachelors, Masters or Doctorate degree
	Post-Secondary degree: Associates, Bachelors, Masters or Doctorate degree and a certificate or license
	Post high school vocational education, non-college business courses, technical/professional training or college credits
	High school diploma/GED
	ESL Certificate
	Reading/writing/math skills present; possible TABE, **no GED/no High School Diploma**
	Reading/writing/basic math skills absent; **illiterate**
Employment (MARK & PUT INITIALS OF EACH ADULT (18 YEARS AND OLDER) NEXT TO APPROPRIATE BOX)	
	FT work **above** minimum wage **with** employer provided benefits
	PT employment **(by choice)** that supplements (adds to) income needs
	Retired or Disabled; not in workforce or seeking employment; **sufficient income**
	FT work **above** minimum wage **without** employer provided benefits
	FT work **at** minimum wage **with or without** employer provided benefits
	Receiving SSI or SSDI
	Employed; Currently on FMLA (no pay)
	PT employment **with or without** employer provided benefits
	Unemployed **with** work history or skills
	Retired or disabled; not in workforce or seeking employment; **insufficient income**
	Unemployed **without** work history or skills

Energy (MARK 1 BOX FOR HOUSEHOLD)	
	Pay all bills without subsidy
	Utilities included in Rent
	Pay all bills with established payment plan
	Pays all or most bills with subsidy or utility payment made by agency on behalf of client
	At risk of loss of energy benefits. (Needs to reapply to continue energy benefits)
	At risk of energy shutoff (notice of shutoff); unable to pay bill(s), needs to apply to obtain benefit
	Utility shutoff; unable to pay bill(s)
	Homeless; utlilities not applicable
Food and Nutrition (MARK 1 BOX FOR HOUSEHOLD)	
	Able to afford **any** food without food programs
	Able to afford **most** food without food programs
	Able to afford food by participating in food programs such as SNAP, WIC or other public or private food programs, **received additional food support to address food insecurity, achieved stabilization**
	Able to afford food by participating in food programs such as SNAP, WIC or other public or private food programs - **NOT experiencing food insecurity**
	Uses food programs such as SNAP, WIC, etc.; **is in need of immediate food assistance, experiencing food insecurity**
	At risk of loss of SNAP, WIC or other food programs; (Needs to reapply to continue food benefits)
	Unable to afford food; uses a food bank, pantry or vouchers
	Unable to afford or obtain sufficient food
Health Insurance – Adults - 18 YEARS AND OLDER (MARK 1 BOX FOR HOUSEHOLD)	
	All adults have health insurance
	At risk of loss of health insurance. (Needs to apply or reapply to continue or supplement health insurance)
	Some adults have health insurance
	No adults have health insurance
Health Insurance – Children - 17 YEARS AND YOUNGER (MARK 1 BOX FOR HOUSEHOLD)	
	All children have health insurance
	At risk of loss of health insurance. (Needs to apply or reapply to continue or supplement health insurance)
	Some children have health insurance
	No children have health insurance
	Does not have minor children in home

Household Budgeting (MARK 1 BOX FOR HOUSEHOLD)	
	Able to pay all bills; expenses do not exceed income; discretionary funds for spending and savings
	Able to pay all bills; expenses do not exceed income; discretionary funds for spending
	Able to pay all bills; expenses do not exceed income
	Unable to pay **some** bills; expenses exceed income
	Unable to pay **most** bills; expenses exceed income
	Unable to pay **any** bills; expenses exceed income
Housing (MARK ONLY 1 BOX FOR HOUSEHOLD)	
	Home ownership (includes condo or co-op)
	Non-subsidized rental housing
	Employer provided housing
	Safe and secure subsidized rental apartment
	Safe and secure subsidized Section 8 housing
	Living with relatives or friends by choice
	Safe and secure subsidized public housing
	At risk of loss of housing. (Needs to reapply to continue housing benefits)
	Safe and secure transitional housing
	Safe and secure domestic violence shelter
	Temporary shelter; hotel, motel or trailer
	Unaffordable home, subsidized or non-subsidized rental
	Cannot make rent or mortgage, unexpected situation
	Home in foreclosure
	Living with relatives or friends due to crisis
	Substandard/unsafe housing
	At risk of eviction
	Homeless

Primary Health Care (MARK ONLY 1 BOX FOR HOUSEHOLD)	
	Access to same provider (medical home) as needed
	Access to various providers as needed
	Limited access to providers
	Emergency Room use only
	No access due to geographic, transportation or financial constraints
Transportation (MARK ONLY 1 BOX FOR HOUSEHOLD)	
	Reliable private transportation/vehicle that meets family needs
	Public transportation that meets family needs, no assistance needed
	Private transportation/vehicle available, **assistance needed**
	Public transportation available, **assistance needed**
	Public or private transportation/vehicle rarely available
	No public or private transportation