Community Action Agency
CINCINNATI | HAMILTON COUNTY
Inspiring Dreams, Improving Lives

SUPPORTIVE SERVICES UNIT – INTAKE FORM

SS#: ____ / ___ / ____ LAST NAME: _____ FIRST NAME: _____

DOB: ____ / ___ / ____ ADDRESS: _____

CITY: _____ ZIP: _____ TELEPHONE:_____

GENDER
☐ FEMALE ☐ MALE

DISABLED
☐ YES ☐ NO

ETHNICITY
☐ BLACK AFRICAN AMER ☐ HISPANIC ☐ ASIAN
☐ WHITE ☐ NATIVE AMER ☐ OTHER

EDUCATION
☐ 0 - 8 ☐ 12+
☐ 9 - 12 ☐ UNKNOWN
☐ HS GRAD/GED ☐ COLLEGE GRAD

FOOD STAMP
☐ YES ☐ NO

HEALTH INSURANCE
☐ MEDICAID ☐ SELF-INS
☐ MEDICARE ☐ NONE
☐ PRIVATE ☐ UNKNOWN

FARMER
☐ FARMER
☐ MIGRANT
☐ SEASONAL

VETERAN
☐ YES
☐ NO

 # IN HSHL
☐

FAMILY TYPE
☐ SINGLE PAR/FEMALE ☐ SINGLE
☐ SINGLE PAR/MALE ☐ COUPLE
☐ TWO PARENT ☐ OTHER

HOUSING
☐ OWN
☐ RENT
☐ HOMELESS
☐ H-W ☐ H-WO
☐ SUBSIDIZED

CUSTOMER INCOME/PERIOD
☐ WEEKLY ☐ ANNUAL
☐ BI-WEEKLY ☐ 13 WEEKS
☐ MONTHLY
AMOUNT ☐

SOURCE OF INCOME
☐ EMPLOYMENT ☐ AFDC/TANF ☐ PENSIONS ☐ WORKER COMP. ☐ INTEREST
☐ EMPLOYMENT ☐ DA ☐ DISABILITY ☐ CHILD SUPPORT ☐ OTHER
☐ SOCIAL SECURITY ☐ SSI/SSD ☐ SELF EMP. ☐ VA
SITE ☐

HOUSEHOLD MEMBERS

SS#						
LAST NAME						
FIRST NAME						
RELATION						
DATE OF BIRTH						
GENDER						
DISABLED						
ETHNICITY						
EDUCATION						
HEALTH INS						
VETERAN						
INCOME PERIOD						
AMOUNT						
SOURCE						

I certify that this statement is true and correct to the best of my knowledge,
and authorize the release of any of all information necessary for verification purposes

Customer Signature_____ Date_____

Staff Signature_____ Date_____