BFNC Buffalo Federation of Neighborhood Centers, Inc.

45 Jewett Avenue, Suite 250 ■ Buffalo, NY 14214 ■Phone (716) 852-5065 ■Fax (716) 852-5065

EMERGENCY & FAMILY SERVICES CLIENT INTAKE FORM

PLEASE PRINT CLEARLY AND COMPLETE BOTH SIDES OF THIS FORM

Please be advised that this application is confidential. Any information regarding sex, ethnicity; education or disability is gathered for statistical reporting only. This agency does not discriminate in any way in provision of services.

Head of Household:

Name:_____ **Date of Birth:**___/___/___
MM/DD/YY

Address:_____ **NY** _____
CITY Zip

Phone Number: _____ **Gender:**____**Male**____**Female**___**Other**___

Age:

___0-5	___45-54
___6-13	___55-59
___14-17	___60-64
___18-24	___65-74
___25-44	___75+

Military Status:_____**Veteran**____**Active**

Race:

___American Indian or Alaska Native___Asian___Black/African American___Native Hawaiian & other Pacific Islander
___White___Other___Multi-Race

Ethnicity: Hispanic, Latin, Spanish Origins: __Yes___No__Unkown

Household Type:

___Single Person____Two Adults NO Children___Single Parent Female___Single Parent Male___Two Parent Household
___Non-related adults w/ children____Multigenerational Household____Other

Housing:____Own __Rent____Other Permanent housing____Homeless____Other

Number of people in household_____(List all on reverse side)

Health Information:

Disabling Condition Yes/No

Heath insurance Yes/No If Yes please check type

___Medicaid____Medicare____State Health Insurance For Adults____State Children's Health Insurance Program____Military Health Care
___Direct Purchase____Employment Based

Education Level:____Grades 0-8____Grades 9-12/Non-Graduate____HS Graduate/Equivalency Diploma____12 Grade + Some Post-Secondary
___2 or 4 yrs. college graduate____Graduate or other Post-Secondary school

Employment Status:____Full-Time____Part-Time____Migrant Seasonal Worker____Unemployed (Short-Term, 6 months or less)____Unemployed (Long-Term, more than 6 months)____Unemployed (not in Labor Force)____Retired

Household Source of Income & Benefits: (Check all that apply and list the amount received. Indicate Yearly, Monthly or Weekly amount by circling the correct response after each).

___No Income_____Workers Comp/Dis $____(YMW)____Employment $____(YMW)_____Retirement Income SS $____(YMW) ___TANF $____(YMW)
____SSI $____(M)____Pension $____(YMW)

Applicant Signature_____Date_____

Is your current hardship a direct result of Covid-19 Pandemic? _ YES _ NO

Additional Household Members (use additional sheet if needed)

	Last Name	First Name	*M/F*	DOB	Disabled **Yes or No**	Active Military **Yes or No**	Veteran **Yes or No**	Relation to Head of Household
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

BELOW THIS LINE IS FOR BFNC OFFICE USE ONLY **Payment** **Food**

Client is requesting Assistance With: **Utility**

Utility Payments, complete Check Request and submit back up documentation

BFNC Staff Member:..... Date:.....