

FRAIL/ ELDERLY IN-HOME REPAIR APPLICATION / INTAKE FORM

Application Date: ____/____/____ Do you own? ____ Rent? ____ Live with family? ____

Client's Name(s): _____

Street Address: _____ Box/Apt No. _____

City, State, Zip: _____

County: _____ Telephone No.: () _____

Number of People in Household: _____ H.H.#: _____
(For Office Use Only)

List All Household Members:

Name	Social Security No.	Date of Birth	Race	Sex	Has Health Ins. or M.A.?

Check all sources of income that are received by members of your household:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Salary or Wages | <input type="checkbox"/> General Assistance | <input type="checkbox"/> Retirement, Pension | <input type="checkbox"/> Food Stamps |
| <input type="checkbox"/> Alimony/Child Support | <input type="checkbox"/> Unemployment Comp. | <input type="checkbox"/> MSA | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Social Security | <input type="checkbox"/> TANF (AFDC, MFIP) | <input type="checkbox"/> Interest/Other | <input type="checkbox"/> Medical Aide |
| <input type="checkbox"/> Self Employment | <input type="checkbox"/> SSI | <input type="checkbox"/> No Income | <input type="checkbox"/> Veteran's Benefits |

Does anyone in your household have a handicap? ____ Who is handicapped? ____

Please describe the handicap: _____

Type of assistance requested: _____

Requested Dollar Amount (up to \$150 per frail/elderly person): \$ _____

Referral Name, Agency, Phone No., Time or Resources Expended: _____

Intake Staff Signature _____ Agency: _____

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Guarantee Made: \$ _____ Fund Used: _____ P.O. No.: _____

Service Completed Date: _____ Follow-up Phone Contact: ف AS400 Completed: ف

Contact Person: Karen Alvstad - West Central MN Communities Action, Inc.
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