HRDC DISTRICT 7

FOOD DISTRIBUTION PROGRAM
PO BOX 364
HARDIN MT 59034
665-2523 Fax: 665-1026

OFFICE: 8:00 to 12:00 & 12:30 to 4:30
FOOD ISSUING ONLY: 8:00 to 11:30 & 12:30 to 3:30

1. **Fill application out completely.**

2. **ALL WAGE STUBS RECEIVED WITHIN THE LAST 30 DAYS!** Copies of wage stubs received by any and all household members. Wage stubs older than 31 days will not be accepted. Social Security Award Letter.

3. **NO-INCOME STATEMENT FORMS** signed and a explanation by all household members **18** years and older.

4. **SOCIAL SECURITY CARDS / BIRTH CERTIFICATES / TRIBAL I.D.** One of these must be provided for each household member unless already on the program file. For some other exceptions please ask the Program Director.

5. A deduction is given to the household if a copy of a utility bill or rent receipt is provided with application.

AFTER APPLICATION IS RETURNED **COMPLETE** IT WILL BE PROCESSED WITHIN SEVEN (7) WORKING DAYS. APPLICANT WILL BE NOTIFIED BY PHONE OR MAIL.

INTER-AGENCY NOTICES ARE CHECKED PERIODICALLY FOR DUAL PART-ICIPATION. PLUS THE FOOD STAMP DISQUALIFICATION LIST.

I understand that I have a choice to participate in either the Food Stamp or the Food Distribution Program. I also understand that I have a choice to change from one program to the other, without penalty, by indication so in Section C. By indication so, I may be certified to participate in the program of my choice beginning NEXT MONTH if I am eligible. I understand that I cannot participate in both programs during the same month. Reference to Federal Regulations: 7 CFR 253.7(e)(2).

Department of Public Health and Human Services, Food Distribution Program, PO Box 8005, Helena MT 59604

DPHHS-FD-001C (REV 12/11)

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS

PENALTIES FOR INTENTIONAL PROGRAM VIOLATIONS

(EFFECTIVE FEBRUARY 28TH, 2000)

EFFECTIVE FEBRUARY 28TH, 2000 ANY APPLICANT OR HOUSEHOLD MEMBER KNOWINGLY, WILLINGLY, AND WITH DECEITFUL INTENT:

1) MAKES A FALSE OR MISLEADING STATEMENT, OR MISREPRESENTS, CONCEALS, OR WITHOLDS FACTS IN ORDER TO OBTAIN FOOD DISTRIBUTION BENEFITS WHICH THE HOUSEHOLD IS NOT ENTITLED TO RECEIVE; OR

2) COMMITS ANY ACT THAT VIOLATES A FEDERAL STATUTE OR REGULATION RELATING TO THE ACQUISITION OR USE OF FOOD DISTRIBUTION PROGRAM COMMODITIES;

3) WILL BE INELIGIBLE TO PARTICIPATE IN THE FDPIR PROGRAM FOR:

   a) 12 months for the first violation;
   b) 24 months for the second violation;
   c) Permanently for the third violation.

ALL SUBSTANTIATED CASES OF (IPV) INTENTIONAL PROGRAM VIOLATIONS MUST BE REFERRED TO TRIBAL, FEDERAL, STATE, OR LOCAL AUTHORITIES FOR PROSECUTION UNDER APPLICABLE STATUTES.

I HAVE READ AND FULLY UNDERSTAND THE PENALTIES FOR THE ABOVE VIOLATIONS.

NAME OF APPLICANT (PLEASE PRINT):_____

SIGNATURE OF APPLICANT:_____

SIGNATURE DATE:_____

DPHHS-FD-001A
(Rev. 11/13)

STATE OF MONTANA
Department of Public Health and Human Services
"THIS INSTITUTION IS AN EQUAL OPPORTUNITY PROVIDER"

NAME	SOCIAL SECURITY NUMBER	CASE NO.

ADDRESS	CITY	COUNTY	ZIP

PART II INCOME STATEMENT (Reference FNS 501 Sections 4600-4640)

Section A Earned Income (Reference FNS 501 Section 4520)

SUBSECTION A-1 CONTRACT & SELF-EMPLOYMENT INCOME (Reference FNS 501 Section 4720-4727)

List all *gross income before taxes* from self-employment, to include payment from roomers and returns on rental property for each household member

NAME	SOURCE	AMOUNT	HOW OFTEN RECEIVED	FOR OFFICE USE ONLY	
		$			Amount to average $
					Amount to average $
					Amount to average $
A. ENTER TOTAL HERE		**$**		**D.**	**Total to average $**

List all *net profits* from the sale of capital goods or equipment within the last 12 months and enter dates of sale.

ITEMS	AMOUNT	DATE	FOR OFFICE USE ONLY	
	$			Amount to average $
				Amount to average $
B. ENTER TOTAL HERE	**$**		**E.**	**Total to average $**

List business expenses and give dates expenses were incurred for the last 12 months

ITEMS	AMOUNT	DATE	FOR OFFICE USE ONLY	
Labor	$			Amount to average $
Stock and Raw Material (seed, fertilizer, etc.)				Amount to average $
Insurance Premiums (equipment, etc.)				Amount to average $
Property Taxes				Amount to average $
Other (Identify)				Amount to average $
				Amount to average $
C. ENTER TOTAL HERE	**$**		**F.**	**Total to average $**

FOR OFFICE USE ONLY

If income listed in Subsection A-1 is the households only means of support, the income must be averaged over a 12 month period, even if the income is received in a shorter period of time. If income in A-1 represents only a part of the household's support, it should be averaged over the period of time it contributes support to the household. If the receipt of income in Sections A & B is reasonably certain, but amounts fluctuate, income may be averaged if it is to the benefit of the household.

Review A & B to determine if income is to be averaged.
If income is to be averaged, determine the number of months in the averaging period.
Calculate the amounts in Subsection A-1 that apply to the averaging period and enter these amounts in D, E & F in the same subsection

1. If income is to be averaged, enter averaging period: From _____ to _____
2. Enter number of months in averaging period (if applicable):..... Number of Months: $_____
3. Add D and E in Subsection A-1 and enter the sum:..... $_____
4. Enter the amount from F in Subsection A-1 ..... $_____
5. Subtract the amount on Line 4 from the amount on Line 3: (No less than 0)..... $_____
6. Divide the amount on line 5 by number of months on Line 2: ..... $_____

SUBSECTION A-2 TRAINING ALLOWANCES (Reference FNS 501 Section 4520C)

Training Allowances				
1. Enter monthly income received.....				
2. Enter monthly tuition and mandatory fees.....				
3. Subtract line 2 from line 1 (if amount is negative, enter 0)				$

SUBSECTION A-3 WAGES, SALARIES & OTHER INCOME FROM EMPLOYMENT

Wages, Salaries or Other Income from Employment					X	Factors Used	
NAME		SOURCE		AMOUNT	X		
					X		
					X		
(Use conversion factors FNS 501 Section 4621)	Total monthly wage and salary income and enter the total on this line						$

Section B Unearned Income (Reference FNS 501 Section 4530)

SOURCE OF INCOME

1. SSI (Supplemental Security Income) -- Gold Checks	9. Other (specify)
2. AFCD (Aid to Families with Dependent Children)	10. Land Lease
3. GA (General Assistance)	11. Pasture Lease
4. Social Security -- Blue/Green Checks	12. Farm Lease
5. Pensions or retirement income	13. Oil or Gas Lease
6. Money from friends or relative (other than loans)	14. Other Leases (specify)
7. Child support and alimony	15. Other Leases (specify)
8. Unemployment or Workers' Compensation	16. Per Capita Payments (specify)

Indicate household member receiving payment and identify payment by above numbers

NAME	NO.	AMOUNT	HOW OFTEN RECEIVED	CIRCLE CONVERSION FACTOR	MONTHLY TOTAL
				1 - 2 - 2.5 - 4 - 4.3	
				1 - 2 - 2.5 - 4 - 4.3	
				1 - 2 - 2.5 - 4 - 4.3	
				1 - 2 - 2.5 - 4 - 4.3	
				1 - 2 - 2.5 - 4 - 4.3	
				ENTER TOTAL $	

Section C Income Deductions

If you pay for child care or other dependent care to enable you to accept or continue work or attend training which is preparatory to employment, enter the monthly amount. Do not enter if these amounts are paid to a member of your household.

	$ _____
Recurring monthly out of pocket medical deduction - over $35	$ _____
Legally required child support payments	$ _____
Premium for Medicare Part B	$ _____
Housing/utility standard deduction ($400)	$ _____
Total	$ _____

Signature _____ Date _____

(Applicant or Authorized Representative)

FOR OFFICE USE ONLY

7.	Enter self-employment amount from line 6 on reverse side	7	$
8.	Enter total monthly amount from Subsection A-2 on reverse side	8	$
9.	Enter total monthly amount from Subsection A-3 on reverse side	9	$
10.	Add lines 7, 8 and 9 and enter total earned income	10	$
11.	Enter 20% of line 10. (Earned income standard deduction)	11	$
12.	Subtract amount on line 11 from amount on line 10 (Net earned income)	12	$
13.	Enter total monthly unearned income from Section B above	13	$
14.	Add amounts from lines 12 and 13. (Total earned and unearned)	14	$
15.	Enter total from Section C, Income Deductions	15	$
16.	Subtract amount on line 15 from amount on line 14	16	$

17. Use the amount on line 16 to determine eligibility.

18. On line 19 and 21 enter the number of each month used for each period beginning with 1.
On line 20 enter the amount under the month, a lump sum payment is expected.

		JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
19.	Averaging Period												
20	Lump Sum Payment												
21	Certification Period												

Signature _____ Date: _____

(Certification Clerk)

Attach to DPHHS-FD-001

DPHHS-FD-001
(Rev. 11/13)

STATE OF MONTANA
Department of Public Health and Human Services

FOOD DISTRIBUTION APPLICATION

OFFICE USE ONLY
Case No.:
I.D. No.:
Expiration Date:
County: Loc:
No. in Household:

APPLICANT: COMPLETE THIS SECTION

NAME (Head of Household)

ADDRESS

CITY, STATE, ZIP CODE | DATE OF BIRTH

PHONE NO. | SOCIAL SECURITY NO.

Racial Ethnic Heritage: Although you are not required to provide this information, your cooperation would be appreciated. If you decline to provide this information, it will in no way effect consideration of your application. Enter appropriate number of household members in each category.

Black (Non-Hispanic) B____ White (Non-Hispanic) W_____

Hispanic H _____ Asian (or Pacific Islander) A_____

American Indian/Alaskan Native I _____

APPLICANT: COMPLETE THIS SECTION

Is any member of this household currently certified to receive Supplemental Nutrition Assistance (SNAP)? ❑ Yes ❑ No

Is any member disqualified from the SNAP Program because of fraud, or disqualified from FDPIR? ❑ Yes ❑ No

Has this household received any income in the present month? ❑ Yes ❑ No

Does this household reside within the Food Distribution Service Area? ❑ Yes ❑ No

How many members of this household receive an AFDC or SSI grant? _____

Monthly shelter and utility expenses

Rent/Mortgage	❑ Yes	❑ No
Property taxes	❑ Yes	❑ No
Electricity	❑ Yes	❑ No
Gas/Propane	❑ Yes	❑ No
Sewer	❑ Yes	❑ No
Trash Collection	❑ Yes	❑ No
Phone	❑ Yes	❑ No
Septic Maintenance	❑ Yes	❑ No

Monthly non-reimbursed out of pocket medical expenses over $35

Medical/Dental
Prescriptions
Ins/Medicare premiums
Home Health Care
Medical related transportation

See certification clerk for complete list of allowable deductions

List household members below	List Social Security Nos. for each Household member	Date of Birth	Status Code	Date
1.	1.	1.	1.	
2.	2.	2.	2.	
3.	3.	3.	3.	
4.	4.	4.	4.	
5.	5.	5.	5.	
6.	6.	6.	6.	
7.	7.	7.	7.	
8.	8.	8.	8.	
9.	9.	9.	9.	
10.	10.	10.	10.	
11.	11.	11.	11.	
12.	12.	12.	12.	
13.	13.	13.	13.	

Status Codes
M – Moved
D – Deceased
I – Ineligible
S – SNAP
X – Delete

Are there any individuals living with this household who provide payment to the household for lodging but not for meals?
❑ Yes ❑ No If yes, give names: _____

Do all of the individuals listed above purchase and prepare their meals together: ❑ Yes ❑ No

OFFICE USE ONLY

If the household is not certified for SNAP in the present month and lives within the Food Distribution Service Area they are automatically eligible if 1 **or** 2 applies.

1. Household has no income nor anticipates any for the current month.
2. All household members received an AFCD or SSI grant.

If the household has no income, or if the household is likely eligible and would otherwise suffer hardship, the household may receive expedited services at the discretion of the local agency. Identity and address must be verified prior to any distribution of commodities

"THIS INSTITUTION IS AN EQUAL OPPORTUNITY PROVIDER"

PENALTIES FOR FRAUD: The State and Federal laws provide penalties, including a fine, imprisonment, or both, for persons found guilty of obtaining donated foods for which they are not eligible by making false statements or

FAILING TO REPORT PROMPTLY any changes in their circumstances. If evidence that such individuals have willfully violated the law, they will be referred to the proper law enforcement authority for investigation and possible prosecution.

ANY WHO AIDS another person to obtain donated foods fraudulently is subject to the same penalties.

I UNDERSTAND that I have the right to a fair hearing if I am not satisfied with the action taken on my application by the Food Distribution Office.

CONFIDENTIALITY: The use of disclosure by any party of any information concerning a client in violation of any rule of confidentiality or for any purpose not directly connected with the administration of the Department's or the Council's responsibilities with respect to the Food Distribution Program is prohibited, except on written consent of the client, his parent if he is a minor, or his court-appointed guardian.

CIVIL RIGHTS: The U.S. Department of agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint or discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust. html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D. C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

USDA is an equal opportunity provider and employer.

APPLICANT: READ ABOVE AND COMPLETE SECTION BELOW

I hereby authorize the following individuals to act as my Authorized Representatives.

NAME _____ NAME _____

I certify that this application has been explained to me (or examined by me) and that the information given is true and correct to the best of my knowledge and belief. I agree to provide the Food Distribution Office necessary information to verify any statements given in this application and give permission to obtain such verification. I will also cooperate fully with State and Federal personnel in a quality control review.
I agree to inform the Food Distribution Office promptly (Within 10 days) of changes in income, living arrangements or other information which I have given, since changes may affect eligibility to receive donated foods.

Signed: _____ Date: _____
(Signature of applicant or authorized representative)

OFFICE USE ONLY

CERTIFICATION ACTION:

Status Code Date _____

Status Code _____

APPROVED from: _____ through _____

DENIED: (Reasons) _____

Signature: _____ Date: _____
(Certifying Clerk)

Status Codes

M Moved
D Deceased
I Ineligible
S SNAP
X Delete

CHECK APPROPRIATE BOX(ES)	Approved for expedited services ❑ Yes ❑ No	Attachment Part II - ❑ Yes ❑ No Attachment Part III - ❑ Yes ❑ No

INTERVIEW WORKSHEET

PLEASE GIVE SPECIFIC DIRECTIONS TO YOUR HOME: COLOR OF YOUR HOUSE? DO YOU HAVE A FENCE? IS THERE TREES? ETC:

_____

_____

IS ANYONE IN THE HOUSEHOLD CERTIFIED FOR FOOD STAMPS? (YES OR NO)
(You cannot receive food stamps and commodities in the same month.)

IDENTIFICATION FOR **ALL HOUSEHOLD MEMBERS** IS NEEDED TO PROCESS THE APPLICATION. (COPIES OF SOCIAL SECURITY CARDS, TRIBAL ID's, BIRTH CERTIFICATES, MEDICAID ID, ETC:)

ARE YOU MARRIED? (YES or NO) IF YES, SPOUSES NAME_____
IS SPOUSE CURRENTLY IN HOUSEHOLD? (YES or NO) IF NO PLEASE EXPLAIN._____

YOUR MAIDEN NAME if applicable _____

WHAT KIND OF INCOME DO YOU HAVE?

UNEARNED: (EXAMPLE: SOC. SEC., WORKERS COMP., UNEMPLOYMENT, ETC.)

_____

DOES ANYONE IN THE HOUSEHOLD WORK? (FULL TIME or PART TIME)

HOW MANY HOURS PER WEEK? _____

PAY RATE PER HOUR? _____

WHEN DO YOU RECEIVE YOUR PAY? _____

DO YOU RECEIVE CHILD SUPPORT? (YES or NO) IF YES HOW MUCH? _____

DO YOU RECEIVE LEASE MONEY? (YES or NO) IF YES HOW MUCH AND WHEN?

_____

CLIENTS SIGNATURE: _____
DATE

SECRETARY OR INTERVIEWER: _____

DATE PROCESSED:_____

DISTRICT VII HUMAN RESOURCES DEVELOPMENT COUNCIL
FOOD DISTRIBUTION PROGRAM
PO BOX 364
HARDIN MT 59034
Phone 665-2523 | Fax 665-1026

STATEMENT OF NO INCOME

I _____ have had no

income/employment from _____ to_____. During this time, I was

able to pay my rent, bills, and buy food, etc by (you must give a written explanation below):

_____

_____

_____

_____

_____

I ATTEST THAT THE INFORMATION STATED ABOVE IS TRUE AND ACCURATE, AND I UNDERSTAND THAT THE ABOVE INFORMATION IF MISREPRESENTED, OR INCOMPLETE, MAY BE GROUNDS FOR IMMEDIATE TERMINATION AND/OR PENALTIES AS SPECIFIED BY LAW.

_____

SIGNATURE DATE

HUMAN RESOURCES DEVELOPMENT COUNCIL

7 North 31ST Street; P.O. Box 2016
Billings, MT 59103
406.247.4732 1.800.433.1411

FOR OFFICE USE ONLY

HH# _____

ENTERED ON COMPUTER _____

PROGRAM INITIALS _____

BASIC INTAKE FORM

SEX CODES
F = Female
M = Male

RACE CODES
BL = Black – Not Hispanic
WH = White – Not Hispanic
AI = Native American/Alaskan Native
HB = Hispanic – Black
HW = Hispanic – White
HI = Hispanic
PI = Pacific Islander
AS = Asian
OT = Other

HOUSEHOLD MEMBER INFORMATION

LAST NAME, FIRST NAME MI	SOCIAL SECURITY NUMBER	RELATIONSHIP TO HEAD OF HOUSEHOLD	BIRTH DATE M	D	YR	Sex	RACE	DISABLED YES / NO	MILITARY STATUS	CHECK ANY THAT APPLY	LAST GRADE COMPLETE OR DEGREE EARNED	WORK STATUS	HEALTH INSURANCE (CHECK ALL THAT APPLY)
1.		**SELF / HEAD OF HOUSE**							☐ Veteran ☐ Active Military ☐ No ☐ N/A	☐ Tribal Member ☐ US Citizen ☐ Registered Alien		☐ Employed Full-Time ☐ Employed Part-Time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (Short-Term, 6 mo. or less) ☐ Unemployed (Long-Term, 6 mo or more) ☐ Unemployed (NOT in Labor Force) ☐ Retired	☐ Healthy MT Kids ☐ MEDICAID ☐ MEDICARE ☐ PRIVATE ☐ V.A. ☐ NONE
2.									☐ Veteran ☐ Active Military ☐ No ☐ N/A	☐ Tribal Member ☐ US Citizen ☐ Registered Alien		☐ Employed Full-Time ☐ Employed Part-Time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (Short-Term, 6 mo. or less) ☐ Unemployed (Long-Term, 6 mo or more) ☐ Unemployed (NOT in Labor Force) ☐ Retired	☐ Healthy MT Kids ☐ MEDICAID ☐ MEDICARE ☐ PRIVATE ☐ V.A. ☐ NONE
3.									☐ Veteran ☐ Active Military ☐ No ☐ N/A	☐ Tribal Member ☐ US Citizen ☐ Registered Alien		☐ Employed Full-Time ☐ Employed Part-Time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (Short-Term, 6 mo. or less) ☐ Unemployed (Long-Term, 6 mo or more) ☐ Unemployed (NOT in Labor Force) ☐ Retired	☐ Healthy MT Kids ☐ MEDICAID ☐ MEDICARE ☐ PRIVATE ☐ V.A. ☐ NONE
4.									☐ Veteran ☐ Active Military ☐ No ☐ N/A	☐ Tribal Member ☐ US Citizen ☐ Registered Alien		☐ Employed Full-Time ☐ Employed Part-Time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (Short-Term, 6 mo. or less) ☐ Unemployed (Long-Term, 6 mo or more) ☐ Unemployed (NOT in Labor Force) ☐ Retired	☐ Healthy MT Kids ☐ MEDICAID ☐ MEDICARE ☐ PRIVATE ☐ V.A. ☐ NONE
5.									☐ Veteran ☐ Active Military ☐ No ☐ N/A	☐ Tribal Member ☐ US Citizen ☐ Registered Alien		☐ Employed Full-Time ☐ Employed Part-Time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (Short-Term, 6 mo. or less) ☐ Unemployed (Long-Term, 6 mo or more) ☐ Unemployed (NOT in Labor Force) ☐ Retired	☐ Healthy MT Kids ☐ MEDICAID ☐ MEDICARE ☐ PRIVATE ☐ V.A. ☐ NONE
6.									☐ Veteran ☐ Active Military ☐ No ☐ N/A	☐ Tribal Member ☐ US Citizen ☐ Registered Alien		☐ Employed Full-Time ☐ Employed Part-Time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (Short-Term, 6 mo. or less) ☐ Unemployed (Long-Term, 6 mo or more) ☐ Unemployed (NOT in Labor Force) ☐ Retired	☐ Healthy MT Kids ☐ MEDICAID ☐ MEDICARE ☐ PRIVATE ☐ V.A. ☐ NONE
7.									☐ Veteran ☐ Active Military ☐ No ☐ N/A	☐ Tribal Member ☐ US Citizen ☐ Registered Alien		☐ Employed Full-Time ☐ Employed Part-Time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (Short-Term, 6 mo. or less) ☐ Unemployed (Long-Term, 6 mo or more) ☐ Unemployed (NOT in Labor Force) ☐ Retired	☐ Healthy MT Kids ☐ MEDICAID ☐ MEDICARE ☐ PRIVATE ☐ V.A. ☐ NONE

Basic Intake Form page 2

HOUSEHOLD ADDRESS INFORMATION

Street Address:_____ **City:**_____ **State:**_____ **Zip:**_____ **County:**_____

Mailing Address:_____ **City:**_____ **State:**_____ **Zip:**_____ **County:**_____

Home Phone:_____ **Cell Phone:**_____ **Message Phone:**_____ **Contact Name:**_____

Housing Structure Type: ___ Apartment/Duplex ___Single Family House ___Mobile Home ___Shelter/Transitional ___None/Homeless

Do you: ___ Rent / ___ Own Live On a Reservation: ___ Yes / ___ No

GROSS MONTHLY INCOME OF ALL HOUSEHOLD MEMBERS

Enter the requested information for all household members, regardless of age or relationship.
(Do not include Food Stamps or any other non-cash assistance programs below.)

NAME OF PERSON RECEIVING INCOME	DATE	SOURCES OF MONTHLY INCOME (EXAMPLE – SOCIAL SECURITY, WAGES, AFDC, ETC.)	TOTAL GROSS INCOME FOR MONTH
1			
2			
3			
4			
5			

READ CAREFULLY BEFORE SIGNING.
IF YOU DO NOT UNDERSTAND SOMETHING, ASK YOUR WORKER

- The collection of personal information on clients is essential to the provision of services at DIST. 7 HRDC: information is collected and stored in the agency Central Database System. Only HRDC and its funding sources access this information.
- The information I (we) give here is subject to verification by HRDC officials. If any information is incorrect, my application may be denied and I may be subject to the criminal penalties for knowingly providing incorrect information.
- I certify, under penalty or perjury, that all my answers are correct and complete to the best of my knowledge, including information about each household member.

Head of Household Signature: _____ **Date:** ____/____/____