

Welcome to the Food Bank of Northern Nevada (FBNN)! To better help you and your family, we ask that you take a few minutes to complete this short form. **Your response will IN NO WAY impact your ability to receive food today or in the future.** We ask these questions as a way to get to know you and to understand how we can better meet the needs of our community. If you have any questions or concerns, please do not hesitate to ask any food bank staff member or volunteer. *Thank you and have a great day!* TEFAP-Only recipients are only required to complete the * items. FBNN is an equal opportunity provider.

Name*: _____ Email**: _____ Gender: Male/Female/Other/Decline

Phone: () _____ Phone Type: Cell** - Landline - Message Date of Birth: _____

Military Active/Veteran Yes No

**May be used to contact you regarding important program updates.

MM/DD/YYYY

Age: _____

Address*: _____

Apt #

City

State

Zip Code

Ethnicity (please mark one) _____ Hispanic or Latino _____ Not Hispanic or Latino

Race (mark all that apply) _____ White _____ American Indian or Alaska Native
 _____ Asian _____ Black or African American
 _____ Pacific Islander or Native Hawaiian

Please list the names, birthdates, genders, ethnicity and race of all the people in your household*:

Full Name of ALL members* Please don't include yourself	Date of Birth MM/DD/YYYY	Gender	Military Active/Vet	Hispanic (Y/N)?	Race	Disabled Y/N

****What is your household's total monthly income? (Include income from ALL members of the household and ALL types of income: wages, Social Security, disability, etc.): \$ _____ per month.**

My income is at or below the income listed for the number of people in my household* Yes No

I am eligible to receive food from TEFAP because my household participates in SNAP, WIC, Free and Reduced Lunch Program (school meals), TANF, or SSI* Yes No

Your input helps us improve advocacy and services and ensure we are doing our best to help all neighbors:

1. Within the past 12 months have you worried that your food would run out before you got money to buy more?

Yes No

2. Within the past 12 months did the food that you bought just not last and you didn't have money to get more?

Yes No

3. Within the past 12 months have you or anyone in the household applied for SNAP (Food Stamps) benefits?

Yes, and it was denied Yes, and I am currently receiving benefits No

4. Are you aware the Food Bank of Northern Nevada helps with SNAP applications?

Yes No

5. Does anyone in the household currently have health coverage?

Yes, whole family No Myself Kids only Spouse only Other household member(s)

6. What type of health coverage do the household members have? (Check all that apply)

Private Insurance Medicare/Medicaid Veteran's Benefits Indian Health Services Disability

7. What are your household's favorite kinds of foods? _____

8. What do you feel causes the need for food assistance? (Check all that apply) Cost of _____ Housing Transportation

Childcare Structural Racism Low Wages Other _____

9. Do you or anyone in your household receive food assistance from any of these programs? (Check all that apply)

Other Food Pantries Free and Reduced Lunch Program Kids Cafe Summer Meals Kids Cafe Dinner Program

Produce on Wheels (POW) Senior Nutrition Wellness Program/CSFP Mobile Harvest

I understand that my basic, identifying and non-confidential service transactions/information will be shared in an electronic shared case database administrated by the Food Bank of Northern Nevada called Oasis Insights.

Signature _____

Date _____

Site/County _____



Sierra County Child Abuse Council. Inc. dba
High Sierras Family Resource Center
PO Box 1016 Loyalton, CA 96118 530.993.1110

Intake Form -

The information collected on this form is required to be completed by all families and individuals receiving assistance through the family resource center. The information is kept confidential to this office and will be reported to funders as congregate data with no names or identifying information unless a Release of Information is completed with your permission. Thank you.

Household Information - Circle one: Rent Own Transitional housing Other_____

Education Level: Circle the highest completed-

High School or Equivalent Some College AA degree BA/BS degree Master's degree

Medical Insurance: Yes___ No___

If yes, what type:_____ Is this insurance from your employer? Yes___ No___

Employed: Yes___ No___

If yes, circle all that apply: Full-Time Part-Time More than 6 mos Less than 6 months

Do you have sources of income outside employment?: Yes___ No___

If yes, circle all that apply: SS SSDI Pension Child Support Other_____

Public Assistance Benefits: Yes___ No___

If yes, circle all that apply:

SNAP MediCAL WIC LIHEAP Child Care Subsidy CalWorks Other:_____

Is there anything else that you would like us to be aware of?_____

Signature

Date