



**CSBG/ Client Information Form**

E-Mail Address: \_\_\_\_\_

SS# \_\_\_\_\_ LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ZIP CODE \_\_\_\_\_ TELEPHONE ( ) \_\_\_\_\_

<b>GENDER</b> <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE		<b>DISABLED</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>ETHNICITY</b> <input type="checkbox"/> B. BLACK/AFRICAN AMER. <input type="checkbox"/> W. WHITE		<input type="checkbox"/> H. HISPANIC <input type="checkbox"/> N. NATIVE AMER.		<input type="checkbox"/> A. ASIAN <input type="checkbox"/> O. OTHER	
<b>EDUCATION</b> <input type="checkbox"/> A. 0 - 8 <input type="checkbox"/> B. 9-12 (NON-GRAD) <input type="checkbox"/> C. HS GRAD/GED				<b>FOOD STAMPS</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>HEALTH INSURANCE</b> <input type="checkbox"/> A. MEDICAID <input type="checkbox"/> B. MEDICARE <input type="checkbox"/> C. PRIVATE		<input type="checkbox"/> D. SELF-INS <input type="checkbox"/> E. NONE <input type="checkbox"/> F. UNKNOWN	
<b>VETERAN</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		<b># IN HSHLD</b>		<b>FAMILY TYPE</b> <input type="checkbox"/> F. SINGLE PAR/FEMALE <input type="checkbox"/> M. SINGLE PAR/MALE <input type="checkbox"/> T. TWO PARENT		<b>HOUSING</b> <input type="checkbox"/> S. SINGLE <input type="checkbox"/> C. COUPLE <input type="checkbox"/> O. OTHER		<b>CLIENT INCOME</b> <input type="checkbox"/> A. WEEKLY <input type="checkbox"/> B. BI-WEEKLY <input type="checkbox"/> C. MONTHLY	
						<input type="checkbox"/> D. ANNUAL <input type="checkbox"/> E. 13 WEEKS AMOUNT:			

**SOURCES OF INCOME**

<input type="checkbox"/> A. EMPLOYMENT	<input type="checkbox"/> C. SOCIAL SECURITY	<input type="checkbox"/> E. DA	<input type="checkbox"/> G. PENSIONS	<input type="checkbox"/> I. OTHER: _____
<input type="checkbox"/> B. UNEMPLOYMENT	<input type="checkbox"/> D. AFDC/TANF	<input type="checkbox"/> F. SSI/SSD	<input type="checkbox"/> H. DISABILITY	<b>SITE:</b> _____

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

ID#									
UNITS									
DATE									

	NAME	DATE
INTAKE		
DATA ENTRY		

EQUAL OPPORTUNITY- It is the policy of the agency to offer equal opportunity to all-persons without regard to race, religion, national origin, sex, age, political affiliation or handicap.

COMPLAINT PROCEDURES- If you have a complaint related to the completion of services that you have received from LEADS, you have the right to file an appeal. This appeal must be made with-in 30 days from the date of services. Please make your appeal in writing to: Terry Boehm, Community Service Director, 160 Wilson Street, Newark, Ohio 43055

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

	SIGNATURE OF CLIENT	DATE
COMMENTS		