

CHAMP Request

- Must be for an immediate need not covered by an existing funding source
- Must be referred by a case manager, advocate, etc.
- Request must not exceed \$100 and is contingent on fund balance
- Must agree to disclose other assistance received
- **PAYMENT CANNOT BE MADE DIRECTLY TO CLIENT**

Please complete this form and return to CHAMP@proactioninc.org

Date: _____
Request made by: Name _____ Organization: _____
Contact Information (phone, email): _____

Applicant Name: _____ Family size: _____

Address: _____ Phone: _____

Purpose For Request For Funds (describe need), how will these funds be a part of a long term solution?:

Name, Phone Number, and Address of where payment should be made:

Amount requested: _____ Date Needed: _____

Please list other funding received or anticipated:

Funding Source and Amount:	Received for:



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Client Intake Form

Please complete this side of the form for the person receiving services today

Social Security Number: --- ---		First Name:		MI:	Last Name:				
Alias or Maiden Name:		Date of Birth: _ / _ / _		Gender: M F Trans		Pregnant: Y N DK	Veteran: Y N	Food Stamps: Y N	Disabled: Y N
Indicate Your Marital Status: Child (No Status) Divorced Domestic Partner Married Separated Single Widowed				Ethnicity- Hispanic/ Latino: Y N		Race: American Indian/ Alaskan Native Asian Black/African American White/Caucasian Hawaiian/Pacific Islander Multi-Race Other			
Education: N/C Child 0-8th 9-12th Nongrad GED High School Grad 12+ Some College 2Year Degree 4Year Degree Graduate Degree						WIC: Y N	Insurance: Private Medicare Medicaid/ Fidelis No Coverage		
House #:	Direction:	Street:			Suffix:	Apartment:	Floor:	County:	
City Name:		Zip Code: --- ---	State:	Intake Date: _ / _ / _		Primary Language:		2nd Language:	
Family Type: Single Parent (Female) Single Parent (Male) Single Person 2 Adults Only 2 Parent Household Other		Email Address:							
Home Phone: () ---			Cell Phone: () ---			Message Phone or Fax: () ---			
Intake Site:		What is Best Way to Contact You: E-Mail Mail Home Phone Cell Phone Message Phone			How Did You Hear About Us: DSS Flyer Event TV Other Agency Radio Newsletter Other				
Housing Situation: Homeless Couch Surfing Other Own Own-Mobile Home Own-Multi Family Rent Runaway Temporary Stable Temporary Unstable							Utility Company:		
Presently Employed: Yes No Unavailable		Last Date Worked: _ / _ / _		Employer Name:			Hours/Week:	Any Limitations: Yes No	
Income Type:	Interval:	Amount:	Income	Interval:	Amount:	Income	Interval:	Amount:	
Alimony			Self Employment			Wages			
Child Support			Social Security			Workers Comp			
Interest/ Dividend			SSDI			Income Verification Date: _ / _ / _			
None			SSI			Document Used to Verify Income: W2 Check Stubs Tax Return Award Letter Other			
Other			TANF						
Pension			Unemployment						
Rental			Veterans Benefits						
Pre Assessment Questionnaire									
Are You Employed: Yes (Full Time) No Job Employed Part Time Retired Student Disabled									
HS Diploma or GED: Yes No		Read/ Write in English: Yes No		Do you have the skills to get a job: Yes No			Safe Affordable Housing: Yes No		
Access to Transportation: Always Usually Sometimes Rarely Never			Child Care: No Children Needed Not Needed		Child Care Enrollment: Unsubsidized Subsidized Provided by Family/Friend Waiting List Not Enrolled				
Caregiver For an Elderly Person: Yes No			Can't Afford Elder Care: N/A Yes No			Children with Health Insurance: No Children All Some None			
Adults with Health Insurance: All Some None			Receiving Services: Yes No			What Services do You Receive: TANF SNAP HEAP Housing Assistance Medicaid/Fidelis			
Information regarding gender, ethnicity, education or disability is collected for statistical purposes only. This information will not be used to determine eligibility. Some of this information is requested by the Federal Government in order to monitor laws prohibiting discrimination against those seeking services. You are not required to furnish this information but are encouraged to do so.									

Please complete this side of the form for the additional members of your household

SSN	First Name	Last Name	Date of Birth	Male or Female	Pregnant	Using the key below please answer the following					Using (Y) Yes or (N) No please answer the following	Monthly Income (\$)	Source of Income
						Relation to Applicant	Ethnicity	Race	Education (age 18+)	Health Insurance			

Marital Status	Relation to Applicant	Ethnicity	Race	Education	Source of Income
A. Single B. Married C. Widowed D. Separated E. Divorced F. Child	A. Mother B. Father C. Child D. Sister E. Brother F. Guardian G. Partner H. Friend I. Spouse J. Grandparent K. Foster Parent L. Foster Child M. Grandchild N. Other _____	A. Hispanic or Latino B. Non-Hispanic or Non-Latino	A. Native American B. Asian C. Caucasian/White D. African American/Black E. Bi-Racial/Multi-Racial F. Hawaiian Pacific Islander G. Other _____	<i>If household member is over age of 18 indicate highest grade completed</i> A. 0-8th grade B. 9-12th grade C. High School Grad D. GED E. 12 + some secondary school F. 2-year College graduate G. 4-year College graduate H. N/C Child under age of 18	<i>Please indicate your source(s) of income</i> A. Employment Only B. Employment + Other sources _____ C. Social Security D. SSDI E. SSI F. Child Support G. TANF H. Interest Dividends I. Unemployment Insurance J. Pension K. Worker's Comp. L. Veteran's Benefits M. No Income N. Other _____