Food Pantry Application

Red River Valley Community Action, 4212 Gateway Dr, Grand Forks ND 58203
Phone: 701-746-5431; Fax: 701-746-0406

Office Use Only

Project Start Date ____/____/____ Staff ____

Name of Head of Household ____

Family Type: ____ Single Person _____ Family _____ Other

Client Record

Name ______________________ ___________________ ____________________________ __________

First | Middle | Last | Suffix

Social Security Number _______ - _____ - ________

U.S. Veteran _____ No _____ Yes

Mailing Address Street ______________________________ City ________________________________

State _____ Zip Code __________________

Primary Phone _______________________ Secondary Phone ____________________

Email Address ____

CLIENT DEMOGRAPHICS

Date of Birth _______/________/_______

Month Day Year

Gender (s) _____ Woman (girl, if child) _____ Man (boy, if child) _____Transgender

_____ Non-Binary _____ Questioning _____ Culturally Specific Identity (e.g. Two-Spirit)

_____ Different Identity (specify): ____

_____ Client prefers not to answer

Race (s) _____ American Indian, Alaska Native, or Indigenous _____ Asian or Asian American

_____ Black, African American, or African _____ Hispanic/Latino/e/o

_____ Middle Eastern or North African _____ Native Hawaiian or Pacific Islander

_____ White _____ Client prefers not to answer

Additional Race & Ethnicity: ____
(optional) specify

Relationship to Head of Household

_____ Self _____ Head of household's spouse or partner _____ Head of household's child

_____ Other relation to head of household _____ Non-relation to head of household

DISABILITIES

Disabling Condition _____ No _____ Yes _____ Client prefers not to answer

Disability Type DK = Client Doesn't Know PNTA = Client prefers not to answer	**Disability Determination**	**If yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently**
Alcohol Use Disorder	___ Yes ___ No ___DK ___PNTA	___ Yes ___ No ___DK ___PNTA
Both Alcohol and Drug Use Disorders	___ Yes ___ No ___DK ___PNTA	___ Yes ___ No ___DK ___PNTA
Chronic Health Condition	___ Yes ___ No ___DK ___PNTA	___ Yes ___ No ___DK ___PNTA
Developmental Disability	___ Yes ___ No ___DK ___PNTA	___ Yes ___ No ___DK ___PNTA
Drug Use Disorder	___ Yes ___ No ___DK ___PNTA	___ Yes ___ No ___DK ___PNTA
HIV/AIDS	___ Yes ___ No ___DK ___PNTA	___ Yes ___ No ___DK ___PNTA
Mental Health Disorder	___ Yes ___ No ___DK ___PNTA	___ Yes ___ No ___DK ___PNTA
Physical Disability	___ Yes ___ No ___DK ___PNTA	___ Yes ___ No ___DK ___PNTA

HEALTH INSURANCE

Covered by Health Insurance ___ No ___ Yes ___PNTA

Medicaid ___ No ___Yes

Medicare ___ No ___ Yes

State Children's Health Insurance Program ___ No ___ Yes

Veteran's Health Administration ___ No ___ Yes

Employer Provided Insurance ___ No ___ Yes

Health Insurance through COBRA ___ No ___ Yes

Private Pay Insurance ___ No ___ Yes

State Health Insurance for Adults ___ No ___ Yes

Indian Health Services Program ___ No ___ Yes

Other (specify) ____________________ ___ No ___ Yes

MONTHLY INCOME

Income from any source ___ No ___ Yes ___ DK ___ PNTA

Alimony or other spousal support ___ No ___ Yes $_____________

Child Support ___ No ___ Yes $_____________

Earned income (employment) ___ No ___ Yes $_____________

General Assistance (GA) ___ No ___ Yes $_____________

Other (specify) __________________ ___ No ___ Yes $_____________

Pension or retirement income from a former job ___ No ___ Yes $_____________

Private disability insurance ___ No ___ Yes $_____________

Retirement income from Social Security ___ No ___ Yes $_____________

Social Security Disability Insurance (SSDI) ___ No ___ Yes $_____________

Supplemental Security Income (SSI) ___ No ___ Yes $_____________

Monthly Income (continued)

Temporary Assistance for Needy Families (TANF) ___ No ___ Yes $____________

Unemployment Insurance ___ No ___ Yes $____________

VA Non-Service-Connected Disability Pension ___ No ___ Yes $____________

VA Service-Connected Disability Pension ___ No ___ Yes $____________

Worker's Compensation ___ No ___ Yes $____________

Total Monthly Income $_______________

NON-CASH BENEFITS

Non-cash benefits from any source ___ No ___ Yes ___ Client prefers not to answer

Supplemental Nutrition Assistance (SNAP) (previously known as food stamps) ___ No ___ Yes

Special Supplemental Nutrition Program for Women, Infants & Children (WIC) ___ No ___ Yes

TANF child care services ___ No ___ Yes

TANF transportation services ___ No ___ Yes

Other TANF-funded services ___ No ___ Yes

Other (specify) _______________________ ___ No ___ Yes

Employed ___ No ___ Yes

If Yes, type of employment ____ Full-time ____ Part-Time ____ Seasonal/Sporadic (including day labor)

If No, why not employed ____ Looking for work ____Unable to work ____ Not looking for work

DOMESTIC VIOLENCE

Survivor of domestic violence? ____ No ____ Yes ____ Client prefers not to answer

If yes, when experience occurred ____ Within the past 3 months ____ 3 to 6 months ago

____ 6 to 12 months ago ____ More than a year ago ____ DK ____PNTA

If yes, currently fleeing? ____ No ____ Yes ____ DK ____ PNTA

Additional Household Members

First Name		First Name	
Last Name		Last Name	
Social Security#		Social Security#	
Birth Date		Birth Date	
Relationship to HOH		Relationship to HOH	
Gender		Gender	
Primary race		Primary race	
Hispanic or Non-Hispanic		Hispanic or Non-Hispanic	
Highest level of education		Highest level of education	
Medical coverage		Medical coverage	
Income type		Income type	
Income Amount/How often		Income Amount	
Work Status		Work Status	
Disabled Y or N		Disabled Y or N	

First Name		First Name	
Last Name		Last Name	
Social Security#		Social Security#	
Birth Date		Birth Date	
Relationship to HOH		Relationship to HOH	
Gender		Gender	
Primary race		Primary race	
Hispanic or Non-Hispanic		Hispanic or Non-Hispanic	
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RRVCA
Food Pantry Certificate Worksheet

Name: ______________________________________ Phone: ___________________________

Address: ____

City/State/Zip: ____

Number of People in household: ___________

How were you referred to our agency? ____

I understand that the Food Pantry is a service program of Red River Valley Community Action Agency and I certify that the gross annual income of all members of my house over 18 years of age does not exceed the income limits stated below for our household size.

HH Size	Annual Income	Monthly Income	HH Size	Annual Income	Monthly Income
1	29,160	2,430	**5**	70,280	5,857
2	39,440	3,287	**6**	80,560	6,713
3	49,720	4,143	**7**	90,840	7,570
4	60,000	5,000	**8**	101,120	8,427

For each additional household member, add $10,280 annually and $857monthly.
Income eligibility based upon 200% of poverty.

Signature: ____ Date: ___________________

Community Action Region IV is an equal opportunity employer

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) Fax: (202) 690-7442; or

(3) Email: program.intake@usda.gov.

____ Reviewed picture id and proof of residency

(01/2003)

I ______________________________________ ______-_____-______ ______________________
(Name) (Social Security Number) (Date of Birth)

give permission to the agency staff and other agencies that are initialed below, to exchange written and verbal information concerning myself and/or dependents. My name as well as other identifying information may be used for referrals and in discussion of my needs with other service agencies and in data collection software.

Initial	Agencies
_____	Grand Forks County Social Services
_____	The Salvation Army
_____	Grand Forks Housing Authority
_____	Prairie Harvest
_____	North Dakota Job Service
_____	Local Law Enforcement & Probation
_____	Northeast Human Service
_____	Grand Forks Public Health
_____	Legal Services of North Dakota
_____	Area Churches: ________________________________
_____	Community Violence Intervention Center
_____	St. Joseph's Social Care
_____	Grand Forks Public Schools
_____	Social Security (SSI & SSDI)
_____	Valley Health
_____	Women, Infant, Children (WIC)
_____	Division of Community Services/Department of Commerce (DCS/DOC)
_____	Other – Please specify: ____________________________
_____	Other – Please specify: ____________________________
_____	Other – Please specify: ____________________________

I understand that this information will be shared only with agencies, software and individuals who need this information to assist me in obtaining services. I understand that my contact information will be used to receive agency updates.

I understand that I have the right to not supply the information requested, however, without this information, the agency may not be able to provide me with the services that I am requesting.

I understand that I may cancel this document at any time by providing any Red River Valley Community Action staff with a written statement asking that these privileges be terminated. This consent will automatically expire at the time of case closure.

Please add me to the RRVCA email list so I can stay informed about new programs, services and special events.

Email Address: ___________________________________

____________________________________ ___________________________
Signature of Client Date

____________________________________ ___________________________
Signature of Staff Date

A PHOTOCOPY OF THIS CONSENT WILL BE CONSIDERED AS VALID AS THE ORIGINAL