

## Food Pantry Intake Form 2023

**Red River Valley Community Action, 4212 Gateway Drive Grand Forks, ND 58203**  
**701-746-5431- Phone      701-746-0406- Fax**

Date Data Collected (use for back date mode in NDHMIS)	Staff Completing Intake
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What is your family type? Single Person ☐ Other:

### CLIENT INFORMATION

First Name	Middle Initial	Last Name	Other Name(s)
Social Security Number <sup>1</sup>		U.S. Military Veteran <input type="checkbox"/> No <input type="checkbox"/> Yes	Date of Birth Age
Race (select all that apply)			
<input type="checkbox"/> American Indian, Alaska Native, or Indigenous		<input type="checkbox"/> Black, African American, or African	<input type="checkbox"/> Native Hawaiian or Pacific Islander
<input type="checkbox"/> Asian or Asian American		<input type="checkbox"/> White <input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused <input type="checkbox"/> Not collected
Ethnicity (select one)			
<input type="checkbox"/> Non-Hispanic/Non-Latin(a) (o) (x)		<input type="checkbox"/> Hispanic/Latin (a) (o) (x) <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not collected	
Gender (select one)			
<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> A gender that is not singularly 'Female' or 'Male'	
<input type="checkbox"/> Questioning		<input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused <input type="checkbox"/> Transgender <input type="checkbox"/> Not collected	

### DISABLING CONDITIONS

Do you have any of the following HUD defined disabling conditions?												
<input type="checkbox"/> No (if no, select no for all types in HMIS)					<input type="checkbox"/> Yes (if yes, select appropriately below)					<input type="checkbox"/> DK	<input type="checkbox"/> R	<input type="checkbox"/> DNC
	Yes	No	DK	R	DNC		Yes	No	DK	R	DNC	
Physical Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, does it affect client's ability to live independently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Health Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Substance Use Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

<sup>1</sup> The Privacy Act of 1974 requires the following information be provided when individuals are requested to disclose their social security numbers. Disclosure of the social security number is voluntary, and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.

## HEALTH INSURANCE

Do you have any health insurance coverage?					
<input type="checkbox"/> No (if no, select no for all types in HMIS)		<input type="checkbox"/> Yes (if yes, select appropriately below)		<input type="checkbox"/> DK	<input type="checkbox"/> R
	Yes	No		Yes	No
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	Private Pay Health Insurance	<input type="checkbox"/>	<input type="checkbox"/>
Medicare	<input type="checkbox"/>	<input type="checkbox"/>	State Health Insurance for Adults (e.g., Sanford Expansion)	<input type="checkbox"/>	<input type="checkbox"/>
State Children's Health Insurance Program	<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Services Program	<input type="checkbox"/>	<input type="checkbox"/>
Veteran's Administration (VA) Medical Services	<input type="checkbox"/>	<input type="checkbox"/>	Employer-Provided Health Insurance	<input type="checkbox"/>	<input type="checkbox"/>
Employer-Provided Health Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>
Health Insurance through COBRA	<input type="checkbox"/>	<input type="checkbox"/>			

Mailing Address:	City:	State:	Zip Code:	County:
Primary Phone Number:	Secondary Phone Number:	Email Address:	Rent:	
			Own:	

## MONTHLY INCOME

Do you have monthly income from any source?		
<input type="checkbox"/> No (if no, select no for all types in HMIS)		<input type="checkbox"/> Yes (if yes, select appropriately below)
	<input type="checkbox"/> DK	<input type="checkbox"/> R
	<input type="checkbox"/> DNC	
	Amount	No
Earned income (i.e., employment)	\$	<input type="checkbox"/>
Unemployment insurance	\$	<input type="checkbox"/>
Supplemental Security Income (SSI)	\$	<input type="checkbox"/>
Social Security Disability Insurance (SSDI)	\$	<input type="checkbox"/>
VA Service-Connected Disability Compensation	\$	<input type="checkbox"/>
VA Non-Connected Disability Pension	\$	<input type="checkbox"/>
Private disability insurance	\$	<input type="checkbox"/>
Workers' Compensation	\$	<input type="checkbox"/>
Temporary Assistance for Needy Families (TANF)	\$	<input type="checkbox"/>
General Assistance (GA)	\$	<input type="checkbox"/>
Retirement income from Social Security	\$	<input type="checkbox"/>
Pension or retirement income from a former job	\$	<input type="checkbox"/>
Child support	\$	<input type="checkbox"/>
Alimony and other spousal support	\$	<input type="checkbox"/>
Other (specify)	\$	<input type="checkbox"/>
<b>Total Monthly Income</b>		<b>\$</b>

## NON-CASH BENEFITS

Do you receive any non-cash benefits?		
<input type="checkbox"/> No (if no, select no for all types in HMIS) <input type="checkbox"/> Yes (if yes, select appropriately below) <input type="checkbox"/> DK <input type="checkbox"/> R <input type="checkbox"/> DNC		
	Yes	No
Special Supplemental Nutrition Program (SNAP) (food stamps)	<input type="checkbox"/>	<input type="checkbox"/>
Special Supplemental Nutrition Program for WIC	<input type="checkbox"/>	<input type="checkbox"/>
TANF Child Care Services	<input type="checkbox"/>	<input type="checkbox"/>
TANF Transportation Services	<input type="checkbox"/>	<input type="checkbox"/>
Other TANF funded services	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Work Status:</b>		
Employed Full Time <input type="checkbox"/>	<input type="checkbox"/> Unemployed (Short Term, 6 months or less)	
Employed Part Time <input type="checkbox"/>	<input type="checkbox"/> Unemployed (Long Term, more than 6 months)	
Migrant Seasonal Farm Worker <input type="checkbox"/>	<input type="checkbox"/> Unemployed (Not in labor force)	
Retired <input type="checkbox"/>		
Youth (14-24) neither working or in school <input type="checkbox"/>		

## Last Grade Completed

<input type="checkbox"/> Less than grade 5	<input type="checkbox"/> Some college	<input type="checkbox"/> Vocational certification
<input type="checkbox"/> Grade 12/High school diploma	<input type="checkbox"/> Associate's Degree	<input type="checkbox"/> Refused
<input type="checkbox"/> School does not have grades	<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Doesn't know
<input type="checkbox"/> GED	<input type="checkbox"/> Graduate degree	<input type="checkbox"/> Not collected

I, \_\_\_\_\_, understand Red River Valley Community Action (RRVCA) will maintain the confidentiality of personal and financial information I provide, except that RRVCA may share information with individuals within RRVCA or acting for RRVCA as necessary to provide services to me, to keep me updated about RRVCA programs, services and initiatives and to administer its programs and RRVCA may disclose information upon request of or as required by RRVCA's funding sources and/or for purposes of internal or external audits, monitoring, investigations or evaluations, and as authorized or required by law, legal process, or court order. For any other purpose, RRVCA will only disclose information with my written consent.

Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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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Disabled Y or N			Disabled Y or N	

# 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 \$857 monthly.  
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](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](mailto:program.intake@usda.gov).

\_\_\_\_\_ Reviewed picture id and proof of residency



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