**Delta Community Action Foundation, Inc.**
**308 SW 2nd St. Lindsay, Ok 73052**
**Phone (405) 756-1100 Fax (405) 756-1104**

**Karen Nichols**
**Executive Director**

| **CUSTOMER INFORMATION** | | | |
|---|---|---|---|
| **Service Requested:** | | | |
| Last Name | First Name | Date of Birth | Today's Date |
| Phone ( ) | Email | SSN (last 4 digits) | Office Location |
| Address | City | | Zip Code |

| **GENDER** | **MARITAL STATUS** | **ETHNICITY** |
|---|---|---|
| ☐ Male ☐Other | ☐ Single ☐ Separated | ☐ Hispanic/Latino |
| ☐ Female | ☐ Married ☐ Divorced | ☐ Non-Hispanic/Latino |

| **INDICATE YOUR RACE (SELECT ONE)** | | |
|---|---|---|
| ☐ American Indian/Alaskan Native | ☐ Caucasian (White) | ☐ Other |
| ☐ Asian | ☐ Hawaiian/Pacific Islander | |
| ☐ Black/African American | ☐ Multi-Race | |

| **INDICATE YOUR EDUCATION (SELECT ONE)** | | |
|---|---|---|
| ☐ 0-8th Grade | ☐ 12+ Some Postsecondary | ☐ Graduate of other post-secondary school |
| ☐ 9-12th/Non-Graduate | ☐ 2 or 4 year College Graduate | |
| ☐ High School Graduate/GED | | |

| **INDICATE YOUR HEALTH INSURANCE (SELECT ONE)** | | |
|---|---|---|
| ☐ No Health Insurance | ☐ Medicaid | ☐ Sooner Care |
| ☐ Direct Purchase | ☐ Medicare | ☐ Indian Health Services |
| ☐ Employment Based | ☐ Military Health Care | |

| **MILITARY STATUS (SELECT ONE)** | **DO YOU RECEIVE FOOD STAMPS?** | **ARE YOU DISABLED?** |
|---|---|---|
| ☐ Active Military ☐ No Status | ☐ Yes | ☐ Yes |
| ☐ Veteran | ☐ No | ☐ No |

| **WORK STATUS (SELECT ONE)** | | **DO YOU HAVE A CDIB CARD?** |
|---|---|---|
| ☐ Employed Full-Time | ☐ Unemployed Short Term >6mos | ☐ Yes |
| ☐ Employed Part-Time | ☐ Unemployed (Long-Term) | ☐ No |
| ☐ Migrant Seasonal Farm Worker | ☐ Unemployed (Not in Workforce) | |
| ☐ Retired | | |

| **NON-CASH BENEFITS (SELECT ONE)** | | **Education/Employment Status** |
|---|---|---|
| ☐ Affordable Care Act Subsidy | ☐ LIHEAP | ☐ Not Working/Not in School |
| ☐ Childcare Voucher | ☐ TANF | ☐ Working/Not in School |
| ☐ SNAP (Food Stamps) | ☐ WIC/Tribal WIC | ☐ In School/Not Working |
| ☐ Section 8 Housing | ☐ None-No Need | ☐ In School/Working |

| **INDICATE YOUR MONTHLY INCOME AMOUNT AND SELECT INCOME SOURCE:** | | **$** |
|---|---|---|
| ☐ Employment | ☐ None | ☐ Social Security ☐Unemployment |
| ☐ TANF | ☐ Pension | ☐ SSDI |
| ☐ Public Assistance | ☐ Alimony | ☐ SSI |
| ☐ Child Support | ☐ Rental | ☐ Veterans |
| ☐ Self-Employment | ☐ Interest/Dividends | ☐ Work Comp |

| **HOUSING STATUS (SELECT ONE)** | | |
|---|---|---|
| ☐ Rent | ☐ Homeless | ☐ Other Permanent Housing |
| ☐ Own | ☐ Other _____ | |

| **HOUSEHOLD TYPE (SELECT ONE)** | | |
|---|---|---|
| ☐ Single Person | ☐ Male Single Parent | ☐ Multigenerational Household |
| ☐ Two Adults NO Children | ☐ Two Parent Household | ☐ Other |
| ☐ Female Single Parent | ☐ Non-related Adults W/ Children | |



**Please complete the other side of the form for additional members of your household.**

| Customer Information | | | | Using the key below please answer the following questions | | | | | | | Using (Y) for Yes or (N) for No please answer the following | | | | | Income | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| First Name | Last Name | Date of Birth | Male or Female | Marital Status | Relation to Applicant | Ethnicity | Race | Education | Education/ Emp. Status | Health Insurance | Served in Military | Food Stamps | WIC | Disabled | Farmer | Income | Source of Income |
| | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |

| Marital Status | Relation to Applicant | Ethnicity | Race | Education | Education/Employment Status | Health Insurance | Source of Income |
|---|---|---|---|---|---|---|---|
| A. Single<br>B. Married<br>C. Domestic Partner<br>D. Divorced<br>E. Separated | A. Brother<br>B. Child<br>C. Father<br>D. Foster Child<br>E. Foster Parent<br>F. Friend<br>G. Grandchild<br>H. Grandparent<br>I. Mother<br>J. Other<br>K. Other Related<br>L. Roommate<br>M. Sister<br>N. Spouse<br>O. Stepfather<br>P. Stepmother | A. Hispanic or Latino<br>B. Non-Hispanic or Non-Latino | A. American Indian or Alaskan Native<br>B. Asian<br>C. Black/African American<br>D. Caucasian (White)<br>E. Hawaiian/Pacific Islander<br>F. Multi-Race<br>G. Other | A. 0-8th grade<br>B. 9-12th grade<br>C. High School Graduate<br>D. GED<br>E. 12 + some secondary school<br>F. 2 -year College graduate<br>G. 4-year College graduate | N. Not Working/ Not in School<br><br>W. Working/Not in School<br><br>I. In School/ Not Working | *Please indicate your source of Health Insurance*<br>A. Medicaid<br>B. Medicare<br>C. State Children's Health Insurance Program (Soonercare)<br>D. State Health Insurance for Adults (Advantage)<br>E. Military Health Care<br>F. Direct Purchase<br>G. Employment Based<br>H. No Insurance<br>I. Indian Health Services | *Please indicate your source of income*<br>A. Employment<br>B. Self-Employment<br>C. Social Security<br>D. SSI<br>E. TANF<br>G. Unemployment<br>H. Veteran Benefits<br>I. Pension<br>J. Workers Comp<br>K. Interest/Dividend<br>L. Rental<br>M. Alimony<br>Q. SSDI<br>R. Child Support<br>S. None |

In accordance with the Policies at the Oklahoma Department of Commerce, you are hereby informed that you have the right to appeal the decision made on this Application and you have the right to expeditious review of your appeal. Should you want to appeal, please contact the Executive Director of this agency, who will furnish you with a copy of the Appeals Procedure.

**********

Do you declare that your income is no more than the income poverty guidelines? Y/N

Signature_____ Date_____

**********

I certify that by accepting this emergency food issuance, I disclaim any right to hold Delta Community Action or the Oklahoma City Food Bank responsible for the food. I further swear under penalty of the law that all information listed above is true to the best of my knowledge.

Signature_____Date_____

**********

**Agency Use:** Funding Source_____ Check #_____ Amount Paid_____ Date Paid_____ Staff Signature_____

Income Verified by: _____ Date:_____

Photo ID Verified by: _____ Date: _____

**********

Reason for services requested:_____

_____

_____

**********

Case Notes:_____

_____

_____

_____

Applications Given for DCAF Programs (Circle all that apply): Weatherization RX for Oklahoma HS/EHS Rental Housing

**********

Captain Input (Signature):_____ Captain Input (Date):_____

Approval of Intake Completion (Signature): _____ Date:_____