



Catholic Charities of the Diocese of Raleigh

Providing Help - Creating Hope - Serving All

EFSP

Cape Fear Regional Office of Catholic Charities Intake/Information Sheet

Prev. contact Program Type of Service Staff/Vol Adult # Ch #

Name: Last name (Please write entire name, all names used) Date:

Address: Telephone #(s): Birth Date: (Zip)

County: Type of ID: ID Verified by:

Employment Employer:

Your job: Current or last date worked

Family Status

Race/Ethnic Group: Asian Black Hisp/Lat Native-Am White Other (Circle all that apply)

Country of Birth:

Please list below everyone who stays in your home. Include yourself and other adults.

Table with columns: Name, Birthdate/ Age, Insurance, School Grade. Rows 1-7.

How many adults live in your home? How many children live in your home? (Please circle all that apply)

Are you: Married / Never been married / Single / Divorced / Separated / Widowed / Living as married

Reason for coming?

What have you done to address these issues?

How did you hear about/ who referred you to Catholic Charities?

What other agencies have you contacted? When? What other agencies have you contacted?

We serve people of all faiths (This information is voluntary and only for reporting purposes, it will not be used for any other reason.) What is your religion? (Please circle one) Catholic / other Christian / Jewish / Muslim / none / Other Name of Church (if any) OVER, PLEASE

Signature of Client:

All of the information on both sides of this document is true, to the best of my knowledge.

APPROVED DENIED DATE AGENCY CHECK # AMOUNT VENDOR



Cape Fear Regional Office of Catholic Charities Family Financial Worksheet

	Monthly Income	Expenses per Month
Wages (Head of household)	\$ _____	Rent/ Mortgage
Wages (Others in the home)	\$ _____	Home Fuel
TANF/ WFFA (Work First)	\$ _____	Lights/ Electric
Unemployment	\$ _____	Water
Disability	\$ _____	Food
Social Security	\$ _____	Medicine/ Medical Care
Food Stamps	\$ _____	Child Care
Child Support	\$ _____	Phone/ Cell phone/ Pager
Subsidized Housing	\$ _____	Cable/ Satellite
Other _____	\$ _____	Car Payment
Other _____	\$ _____	Car Costs (Gas, Repairs, Ins.)
WIC	\$ _____	Insurance (Life, Medical)
Medicaid for children	\$ _____	Credit Cards (or other debt)
Medicaid for adults	\$ _____	Furniture, Clothing, other household costs
Medicare	\$ _____	Other _____
Total Income	\$ _____ per month	Total Expenses
		\$ _____ per month

Signature of Client: _____

All of the information on both sides of this document is true, to the best of my knowledge.

_____ APPROVED DATE _____ AGENCY CHECK # _____ AMOUNT _____ VENDOR _____
 _____ DENIED

Program _____
Type of Service _____
Worker _____

**Catholic Charities
CASE NOTES for FEMA**

Client Name _____ **Birthdate** _____ **ID #** _____

Date	Please sign and date each entry
	Pender County Resident:
	Original Bill in Client Name/Address:
	Current Proof of Income: