Schuylkill Community Action- Intake Form

Please complete the following information for you and all household members. Failure to complete this form in its entirety may delay the processing of your assistance. **Continue on the back for additional household members.**

	Head of household	Household member 1	Household member 2	Household member 3	Household member 4
Name					
Social Security Number					
Date of Birth					
Gender					
Race					
Ethnicity-Hispanic/ Latino- (Yes or No)					
Disabled (Yes/No)- If yes, physical or mental					
Military- (Active, Veteran, or No)					
Employed- (Yes/No) If yes, Full or Part-time					
Health Insurance- (Yes/No) If yes, Private or Subsidized					
Highest level of education completed					

Health insurer (Circle One)	UPMC	Geisinger	Health Partners Plan	Amerihealth	Other

Name ______________________ **Date** ______________________

Additional Household Members

	Household member 5	Household member 6	Household member 7	Household member 8	Household member 9
Name					
Social Security Number					
Date of Birth					
Gender					
Race					
Ethnicity-Hispanic/ Latino- (Yes or No)					
Disabled (Yes/No)- If yes, physical or mental					
Military- (Active, Veteran, or No)					
Employed- (Yes/No) If yes, Full or Part-time					
Health Insurance- (Yes/No) If yes, Private or Subsidized					
Highest level of education completed					