



Application

Please use an ink pen and print clearly

FIRST NAME _____ LAST NAME _____

DATE OF BIRTH (MONTH/DAY/YEAR): _____ AGE _____

HEAD OF HOUSEHOLD? YES NO

STREET ADDRESS: _____

MAILING ADDRESS: _____

CITY/STATE/ZIP CODE: _____

COUNTY: _____

PHONE NUMBER: _____

Income source	Amount (\$\$)	Frequency (monthly, annual?)

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GENDER (SELF-IDENTIFIED): **MALE** **FEMALE** **OTHER**

ETHNICITY (CIRCLE ALL THAT APPLY)

AFRICAN AMERICAN/BLACK	AMERICAN INDIAN	ASIAN
CAUCASIAN/WHITE	MIDDLE EASTERN	HISPANIC/LATINO
ALASKAN NATIVE	NATIVE HAWAIIAN/PACIFIC ISLANDER	

EDUCATION (CIRCLE THE HIGHEST ACHIEVED)

LESS THAN HIGH SCHOOL	HIGH SCHOOL GRADUATE/GED
SOME COLLEGE/ASSOCIATE'S DEGREE	BACHELOR'S DEGREE
MASTER'S DEGREE OR HIGHER	

EMPLOYMENT (CIRCLE CURRENT STATUS)

FULL-TIME	PART-TIME	SEASONAL
RETIRED	UNEMPLOYED	DISABLED

MARITAL STATUS (CIRCLE CURRENT STATUS)

MARRIED DIVORCED SINGLE WIDOW/WIDOWE SEPARATED

MEANS OF TRANSPORTATION (CIRCLE CURRENT STATUS)

PERSONAL VEHICLE	FRIENDS OR FAMILY VEHICLE
WALK OR BIKE	PUBLIC TRANSPORTATION

HOUSING

RENT	MORTGAGE	HOTEL/TEMPORARY
GROUP HOME	STUDENT HOUSING	MILITARY HOUSING
HOMELESS	SHELTER/RECOVERY	OWN

WOULD YOU LIKE HELP APPLYING FOR FOOD STAMPS?

YES NO

BENEFITS RECEIVED (CIRCLE ALL THAT APPLY)

SNAP (FOOD STAMPS)	TEMPORARY ASSISTANCE FOR NEEDY FAMILIES)
MO HEALTH NET (MEDICAID)	SUPPLEMENTAL SECURITY INCOME (SSI)
SUPPLEMENTAL AID TO THE BLIND (AB)	PUBLIC HOUSING ASSISTANCE
SUPPLEMENTAL PAYMENTS	FREE OR REDUCED SCHOOL MEALS
WIC	CHIP
NONE	LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

OTHER (CIRCLE ALL THAT APPLY)

AT RISK OF BEING HOMELESS	DISABLED	NONE
VETERAN	ACTIVE MILITARY	

DO YOU HAVE ANY OF THE FOLLOWING TYPES OF INSURANCE? (CIRCLE THOSE THAT APPLY)

FULL HEALTH	PARTIAL HEALTH	DENTAL
VISION	MEDICARE	NONE
MEDICAID		

LIST OTHER MEMBERS OF YOUR HOUSEHOLD:

First/last name	Birthdate	Gender	Ethnicity	Relationship to applicant

Release of Information Authorization.

Douglass Community Services, under the direction of the Food Bank for Central and Northeast Missouri Assistance Network (here after , the Food Bank), retains client information in the Oasis Insight network. The Food Bank administers Oasis Insight on behalf of participating agencies, like Douglass Community Services.

I understand that all information gathered about me is personal and private and that I do not have to participate in Oasis Insight. I have had an opportunity to ask questions and review the information I have provided, which is authorized by this release for the Oasis Insight Assistance Network Participating Agencies to share. I also understand that information about non-confidential services provided to me by participating agencies may be shared with other participating agencies. This Release of Information Authorization will be in effect for 3 years from the dated noted by the signature unless I make a formal request to Douglass Community Services that I no longer wish to participate in Oasis Insight.

Client Signature _____ Date _____

Representative of Douglass Community Services _____ Date _____

Return this form to Douglass Community Services, 711 Grand Ave, Hannibal, MO 63401. Address questions by calling 573.221.3892