☐ **UPDATE HH INFO (Internal use only)**

CITY OF PHOENIX FAMILY SERVICES CENTERS SERVICE QUESTIONNAIRE

☐	☐	☐
Travis L. Williams 4732 S. Central Ave. 85040 (602) 534-2433	**John F. Long** 3454 N. 51st Ave. 85031 (602) 534-2433	**Sunnyslope** 914 W. Hatcher Rd. 85021 (602) 534-2433

Appointment Type: _____

Appointment Date: _____

Emergency Assistance Appointment Line: (602) 534-AIDE or (602) 534-2433
Toll Free: 1-(866)-882-1778

Please complete the following information for the Applicant requesting benefits:

Date of Birth	**First Name**	**Last Name**	**Middle Initial**

Social Security Number (if applicable)	**Gender (Circle):** **Male / Female/ Other**	**Ethnicity:** **Hispanic/ Latino/ None**	**Race:**

Street Address	**Apt/Lot/Unit**	**City**	**Zip Code**

Housing Type: (Circle) **Rent / Own / Subsidized Housing / Homeless/ Permanent Housing/ Other:**	**Monthly Housing Payment:** **$**	**Phone # (Cell / Home / Message)** **( )**	**Work Phone #** **( )**

Medical Insurance Type?	**Last School Grade Completed?**	**U.S. Citizen or U.S. National?** **If not, immigration status?**

Work Status? **Employed Full Time/ Part Time/ Migrant Seasonal Farm Worker/ Unemployed less than 6 months/ Unemployed more than 6 months/ On Leave/ Disabled/ Retired/ Other:** _____ _____ _____	**Marital Status?** **Never Married / Married/ Widowed / Separated / Divorced / Partner/ Other:** _____ _____ _____	**How long have you lived in Arizona?** **Years:** _____ **Months:** _____	**How long have you lived in Maricopa County?** **Years:** _____ **Months:** _____

Do you want assistance with finding employment? **□Yes □No**	**Is anyone in your household?**
	Pregnant □Yes □No If yes, who? _____ **Elderly (60+) □Yes □No If yes, who?** _____ **Disabled □Yes □No If yes, who?** _____ **Homebound □Yes □No If yes, who?** _____ **Veteran □Yes □No If yes, who?** _____ **Active Military □Yes □No If yes, who?** _____

Briefly explain what caused you to seek help with financial assistance:
We can work together towards a solution through case management.
Case management is a way for us to work together to help support you through your concerns. We will work in partnership to create an action plan with goals that you wish to reach. We'll help you find resources and ways to help you reach those goals.
Are you interested in case management? Yes____ No____

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EVERYONE LIVING IN YOUR HOUSEHOLD

List Household Member Information Below:

Name	Age	Date of Birth	Social Security Number (If applicable)	Ethnicity and Race	Gender	Medical Insurance Type	Relationship (to the applicant)	Last Grade Completed	Work Status (i.e. Employed FT, Employed PT; etc.)

****To add additional members, please request an additional member page from the caseworker ****

PLEASE SHOW FOR YOURSELF AND ALL HOUSEHOLD MEMBERS THE FOLLOWING:

1) **ALL MONEY RECEIVED (GROSS INCOME BEFORE DEDUCTIONS) FOR THE LAST 30 DAYS**
2) **ALL OF YOUR BILLS FOR THE LAST 30 DAYS FOR ALL HOUSEHOLD MEMBERS**

ARE YOUR UTILITIES ON or OFF? (Circle)
CIRCLE YOUR UTILITY COMPANY: APS SRP SW GAS

DO YOU PAY CITY OF PHOENIX WATER? YES _____ NO _____

A. Job/Employment (For ALL Household Members)
Any full or part-time work, day labor, babysitting, landscape, repairing cars, housekeeping, etc.

Name of Individual Receiving Income	Date Received	Gross Amount

B. Social Security (SS, SSI, SSDI)

Name of Individual Receiving	Date Received	Gross Amount

C. Government Assistance (TANF, TPEP, Grant Diversion)

Name of Individual Receiving	Date Received	Gross Amount

D. Supplemental Nutrition Assistance Program

Name of Individual Receiving	Date Received	Gross Amount

E. Unemployment Insurance, Workman's Compensation

Name of Individual Receiving	Date Received	Gross Amount

F. Child Support (For all states, if applicable)

Name of Individual Receiving	Date Received	Gross Amount

G. Other Income (Per Capita; Retirement/Pension, etc.)

Name of Individual Receiving	Date Received	Gross Amount

H. VA (Veterans' Comp., VA Service-Connected Disability/ VA Non-Service-Connected Disability)

Name of Individual Receiving	Date Received	Gross Amount

Expenses:

1. **Electricity:** _____ $_____
   Account Number
2. **Water:** _____ $_____
   Account Number
3. **SW Gas:** _____ $_____
   Account Number
4. **Car Payment/ Transportation** $_____
5. **Child/ Dependent Care** $_____
6. **Food** $_____

I. Alimony/ Spousal Support

Name of Individual Receiving	Date Received	Gross Amount

I certify the above information is a true and accurate statement of my living circumstances. I authorize the City of Phoenix to verify the information provided by me to determine eligibility for assistance.

X_____
CLIENT (APPLICANT) SIGNATURE

City of Phoenix
Human Services Department
AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ SS# (if applicable): _____ Date of Birth: _____

I_____ (print full name exactly as on document), hereby authorize the City of Phoenix Human Services Department and the utility companies that provide or provided me services to release any and all information requested concerning myself or my household members to ensure a thorough assessment of my household's situation is completed. I understand the completion of an assessment is not a guarantee financial services will be provided.

I hereby authorize the City of Phoenix Human Services Department and the utility companies to share and exchange information concerning myself or any member of my household with the following organizations:

Arizona Department of Economic Security
Social Security Administration
Landlord or Mortgage Company listed on this questionnaire
SRP/SWG/APS/City of Phoenix Water Services Department
Current, Past or Prospective Employers
Arizona Community Action Association (dba Wildfire)
All City of Phoenix Departments

I understand I may revoke this authorization at any time, except to the extent action based on this authorization has already been taken. Unless I revoke this authorization earlier it will expire six months from the date of my signature. If requested, I understand this document may be provided to any and all the agencies/persons identified on this release of information.

X Client Signature: _____ Date: _____

City of Phoenix
Human Services Department
AFFIDAVIT OF IDENTITY/AFFIDAVIT OF DOCUMENTATION

I, _____ (print full name exactly as on document), hereby affirm, upon penalty of perjury, that I presented documentation to the City of Phoenix for the purpose of obtaining a benefit from the City, that I am lawfully present (if applicable) in the United States, and that I am the person stated on the document.

X Client Signature: _____ Date: _____

Media Request
Are you willing to discuss your experience at the City of Phoenix Family Services Center with the media (newspaper and/or television reporters, phone interview, etc.)? Yes_____ No_____

If yes, how do you prefer to be contacted? Phone: _____ or Email: _____

If you answered yes, your information may be forwarded to the Arizona Community Action Association who will contact you for additional information.

Participant Input:
Would you be interested in joining the Human Services Department Human Services Commission? Your participation would provide a voice for low-income residents of the City of Phoenix. Yes_____ No_____

If you answered yes, your information will be forwarded to a City of Phoenix staff member who may contact you for additional information as well as provide you more details about this opportunity.

Authorized staff use only:
- ☐ Verification of Income
- ☐ Verification of HH address/ occupancy
- ☐ Verification of school enrollment