



# CLIENT INTAKE 2024-2025

Please clearly print all information:  
(all information is confidential)

(Office Only)	
Food Pantry ID # _____	Declined TEFAP <input type="checkbox"/>
EmpowOR Yes <input type="checkbox"/> No <input type="checkbox"/>	

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Rent: Yes  No

Residential Street Address \_\_\_\_\_

Homeowner: Yes  No

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Total Household Size: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Language spoken at home: \_\_\_\_\_

Email \_\_\_\_\_

Interested in speaking with a  
Womanspace counselor about  
domestic violence? Yes  No

Country of origin: \_\_\_\_\_

Members of the household: including yourself

First and Last Name	Date of Birth Age	Social Security #	Marital Status	Disabled	Income Type	Income Amount & Frequency	Ethnicity	Grade Completed
	Month / Day / Year ____ / ____ / ____ Age: _____	____ - ____ - ____	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow	<input type="checkbox"/> Disabled <input type="checkbox"/> Veteran <input type="checkbox"/> Neither	<input type="checkbox"/> SSI <input type="checkbox"/> SSD <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed	\$ _____ <input type="checkbox"/> weekly <input type="checkbox"/> bi-monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> monthly		
	Month / Day / Year ____ / ____ / ____ Age: _____	____ - ____ - ____	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow	<input type="checkbox"/> Disabled <input type="checkbox"/> Veteran <input type="checkbox"/> Neither	<input type="checkbox"/> SSI <input type="checkbox"/> SSD <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed	\$ _____ <input type="checkbox"/> weekly <input type="checkbox"/> bi-monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> monthly		
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Under penalty of perjury, I hereby certify to the best of my knowledge and belief, that the above statements are true.

Client's Signature \_\_\_\_\_

Case Manager's Signature \_\_\_\_\_

Date \_\_\_\_\_

### RISE OFFICE USE ONLY

Annual Household Income: \_\_\_\_\_  125%  185%  200%  Over

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> All-in-One Outcomes - GDocs        | <input type="checkbox"/> HGP Database - GDocs              | <input type="checkbox"/> SNAP <input type="checkbox"/> NJFamily Care <input type="checkbox"/> School Lunch |
| <input type="checkbox"/> Database - GDocs                   | <input type="checkbox"/> TBP Database - GDocs              | <input type="checkbox"/> Unemployment <input type="checkbox"/> Emergency Assistance                        |
| <input type="checkbox"/> FP Distribution - GDocs            | <input type="checkbox"/> Hot Meal - GDocs                  | <input type="checkbox"/> Other/Reason for visit: _____   |
| <input type="checkbox"/> EmpowOR                            | <input type="checkbox"/> Manila Folder - Food Pantry TEFAP | _____  |
| <input type="checkbox"/> Internal Case Note - In house file | <input type="checkbox"/> Updated (Date): _____             | _____  |
| <input type="checkbox"/> In Remind                          | <input type="checkbox"/> Time: _____                       | _____  |



Formerly Community Action Service Center  
Leslie Koppel, Executive Director

**CLIENT INFORMATION RELEASE/  
AUTORIZACION DE INFORMACION DEL CLIENTE**

I/Yo, \_\_\_\_\_, hereby give permission to/autorizo a \_\_\_\_\_ of RISE – A COMMUNITY SERVICE PARTNERSHIP to release the following confidential information/para que revele la siguiente información confidencial:

*Data necessary to determine eligibility for service (may include financial information)*

This information may be released to New Jersey referral agencies including, but not limited to, Mercer County Board of Social Services, Catholic Charities, City of Trenton FEMA Program, Crisis Ministries, Home Front, St. Anthony of Padua, Salvation Army, State of New Jersey Homeless Prevention Program, Better Beginnings Day Care, Jewish Family Services, and Womanspace & AAMH, Child Protection & Permanency, Mercer Street Friends, USDA.

The purpose or need for such disclosure at any time is to determine and coordinate eligibility for services and document statistics, except to the extent that action has been taken in reliance to other agencies and otherwise will remain in effect for the time your file is active.

This information has been disclosed to you from the records whose confidentiality is protected by federal laws. Federal regulation prohibits you from making any further disclosure of it without the specific written authorization to which it pertains, or as otherwise permitted by such regulations. Furthermore, you agree to have photographs and video of your family taken for use in future RISE publications.

*Datos necesarios para determinar la elegibilidad del servicio, (lo que también podría incluir información financiera)*

Esta información puede ser revelada a las siguientes agencias de referencias en New Jersey, pero tampoco se les será limitada. Las agencias siguientes son: Mercer County Board of Social Services, Catholic Charities, City of Trenton FEMA Program, Crisis Ministries, Home Front, St. Anthony of Padua, Salvation Army, State of New Jersey Homeless Prevention Program, Better Beginnings Day Care, Jewish Children and Family Services, Womanspace & AAMH, Child Protection & Permanency, Mercer Street Friends, USDA.

El propósito o la necesidad para revelar cierta información es para coordinar la elegibilidad de los servicios y documentos estadísticos. Esta información puede ser dada dependiendo de la agencia que la solicite. La necesidad de revelar dicha información seguirá estando vigente excepto cuando ya se haya tomado una acción en colaboración con otras agencias de lo contrario esta información se mantendrá en efecto el tiempo que su expediente este activo.

Esta información se le ha sido revelada a Usted, de documentos que están protegidos por las leyes federales. Regulaciones federales nos prohíben hacer cualquier revelación de la misma, sin antes obtener un consentimiento escrito por la persona a quien tal información pertenece, siempre y cuando se le sea permitido por ciertas regulaciones. Está de acuerdo de que fotografías y videos tomados de usted y su familia podrán ser usados para futuras publicaciones de RISE.

\_\_\_\_\_  
Signature of client or person authorized / Firma del cliente o persona autorizada

\_\_\_\_\_  
Date / Fecha

\_\_\_\_\_  
Signature of witness / Firma del testigo

\_\_\_\_\_  
Date / Fecha



# EMERGENCY FOOD REGISTRATION FORM

## Intake Information

Clients must be residents of the State of New Jersey

Date: \_\_\_\_\_ LDA \_\_\_\_\_ EFO \_\_\_\_\_

Name (Print): \_\_\_\_\_ Birthdate: \_\_\_\_\_

Street Address: \_\_\_\_\_ Town & zip code: \_\_\_\_\_

Phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_

Number of adults in household: \_\_\_\_\_ Number of children under 18 in household: \_\_\_\_\_

### QUALIFYING REASON (PLEASE CIRCLE)

1. **TANF (Temporary Assistance for Needy Families – Social Services Program)**
2. **SNAP/Food stamps - Ran out/insufficient Lost Stolen Not received**
3. **SSI (Supplemental Security Income) – NOT SOCIAL SECURITY**
4. **WIC (Women, Infants, and Children)**
5. **MEDICAID**
6. **LOW INCOME (185% of poverty)- SELF DECLARATION**
7. **DISASTER (Other – can be divorce, domestic violence, unusual expense, loss of employment, etc.)**

**Please explain:** \_\_\_\_\_

I am accepting a charitable donation of food from the Emergency Food Pantry. I hereby relinquish the Food Pantry of all liability of any nature whatsoever and accept the food products “as is” and at my own risk.

“I certify that my total yearly gross household income is at or below 185% of the poverty level, OR that my household participates in the program(s) that I have checked on the Emergency Food Registration Form. I will also notify the Pantry, if there are changes to my income or qualifiers which may cause me to become ineligible for the TEFAP foods.”

**CLIENT SIGNATURE** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Interviewer Name: \_\_\_\_\_

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the responsible state or local agency that administers the program or USDA’s TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant’s name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**  
U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410; or
2. **fax:**  
(833) 256-1665 or (202) 690-7442; or
3. **email:**  
[program.intake@usda.gov](mailto:program.intake@usda.gov)

# THE EMERGENCY FOOD ASSISTANCE PROGRAM (TEFAP)

## Proxy Form / Formulario De Poder

I give my permission for the undersigned to sign for receipt of my TEFAP commodities, due to my inability to pick up my TEFAP commodities.

Doy permiso para que la persona abajo firmante, firme la aceptacion de mis productos debido a mi incapacidad para recogerlos

Client / Cliente

Proxy / Apoderado

\_\_\_\_\_  
Print name of client  
Nombre impreso del cliente

\_\_\_\_\_  
Print name of Proxy  
Nombre impreso del destinatario

\_\_\_\_\_  
Signature of Client  
Firma del cliente

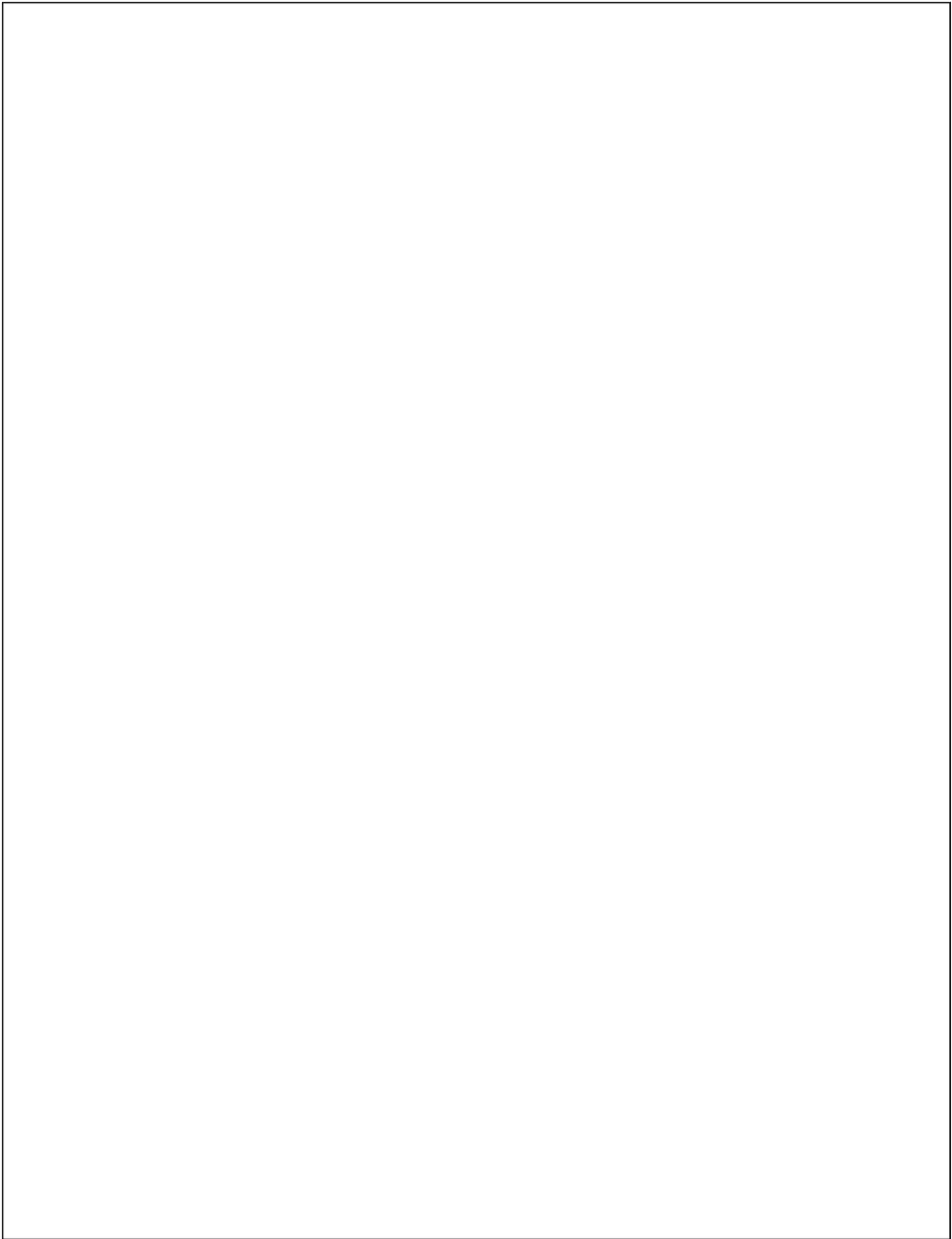
\_\_\_\_\_  
Signature of Recipient  
Firma del destinatario

\_\_\_\_\_  
Date / Fecha

\_\_\_\_\_  
Relationship / Relacion

\_\_\_\_\_  
Account #

\_\_\_\_\_  
Pantry





Mercer County, New Jersey  
 Community Services Block Grant (CSBG) Program  
 Customer Satisfaction Survey



Please take a moment to complete this evaluation survey. Your response will greatly benefit the CSBG program by helping agencies analyze their performance and locate any areas of improvement. You may write additional notes at the bottom of the survey. All survey responses are anonymous. Thank you for taking a moment to give us your feedback!

1. How satisfied are you with the **intake/enrollment** process at this agency?

<input type="checkbox"/>	Very Satisfied	<input type="checkbox"/>	Not Satisfied
<input type="checkbox"/>	Satisfied	<input type="checkbox"/>	Neutral/Indifferent

2. Overall, how satisfied are you with the **services** that are available to you from this agency?

<input type="checkbox"/>	Very Satisfied	<input type="checkbox"/>	Not Satisfied
<input type="checkbox"/>	Satisfied	<input type="checkbox"/>	Neutral/Indifferent

3. Overall, how satisfied are you with the **agency's** case management services, informational services and any addition services provided?

<input type="checkbox"/>	Very Satisfied	<input type="checkbox"/>	Not Satisfied
<input type="checkbox"/>	Satisfied	<input type="checkbox"/>	Neutral/Indifferent

4. The **agency and the staff** are well organized and informed about their programs and services. I left the agency today feeling knowledgeable about the discussed services and am confident I am receiving adequate service.

<input type="checkbox"/>	Strongly Agree	<input type="checkbox"/>	Disagree
<input type="checkbox"/>	Agree	<input type="checkbox"/>	Neutral/Indifferent

5. One a scale from 1 to 10 (*1 being least likely and 10 being most likely*) how likely are you to recommend this agency to a family member and/or friend in need of their services? Circle your answer.

1      2      3      4      5      6      7      8      9      10

6. How did you hear about this agency? **Answer:** \_\_\_\_\_

**ADDITIONAL FEEDBACK :** \_\_\_\_\_



JOHN O. WILSON  
 HAMILTON NEIGHBORHOOD CENTER, INC.

