The Plainville Community Food Pantry, Inc
Tel: (860) 747-1919 • Fax: (860) 793-2475
P.O. Box 233 • 54 South Canal St • Plainville, CT 06062
www.plainvillefoodpantry.org

FAMILY #
(If Applicable)

Plainville Community Food Pantry-Application

PLEASE PRINT AND FILL-IN ALL OF THE INFORMATION REQUESTED, IN THE SPACES PROVIDED. IF YOU SKIP ANY PART OF THE APPLICATION IT WILL BE CONSIDERED AN INCOMPLETE APPLICATION.

Referral Source: _____ **Date:** _____

Name: _____ **Last Four of SS#** XXX-XX-_____

Address_____**Town**_____

Date of Birth: _____ **Age:** _____ **Veteran:** ____ **Disabled:** ____

Phone # (_____) _____-_____ **Cell #** (_____) _____-_____
Are you Vaccinated Yes_____ No_____
Spouse/Roommate: _____ **Soc. Sec. #:** XXX-XX-_____

Address: _____ Town**:** _____

Date of Birth: _____ **Age:** _____ **Veteran:** ____ **Disabled:** ____
Are you Vaccinated Yes_____ No_____

State Client ID #: _____ **Name of your State Social Worker:** _____
(If Applicable)
Total Number of people in the household: _____.
(Please include everyone in the household/seeking assistance or not)

Adults: _____ (18 -59) **Children:**_____ (0-17) **Seniors:** _____ (60+)

Reason for assistance: _____
(See next page for additional space)
Source of Income (including cash assistance)**:**_____

Weekly Income: $ _____ **Monthly Income: $** _____ **Any Other Income: $** _____
(Incl. income from other household members)

EXPENSES: (Please fill-in applicable bill amounts per month)

Rent/Mortgage	**$**_____	**Car Payment**	**$**_____	**Homeowners Insurance**	**$**_____
Electric	**$**_____	**Auto Insurance**	**$**_____	**Water**	**$**_____
Gas/Oil	**$**_____	**Credit Cards**	**$**_____	**Sewer**	**$**_____
Phone	**$**_____	**Daycare**	**$**_____	**Property/Car Taxes**	**$**_____
Cell Phone	**$**_____	**Medical**	**$**_____	**Savings Acct. Balance**	**$**_____
Cable	**$**_____	**Prescriptions**	**$**_____	**Checking Acct. Balance**	**$**_____
Internet	**$**_____	**Life/Health Ins**	**$**_____	**Retirement Acct. Balance**	**$**_____

If you have credit card balances what is the total amount owed $_____

Do you receive SNAP (Food Stamps)? - - - - - - - - - ☐ **Yes $** _____ (Per Month) ☐ **No**

Do you receive WIC? - - - - - - - - - - - - - - - - - - - ☐ **Yes** ☐ **No**

Do your children receive free/reduced school lunch? ☐ **Yes** ☐ **No**

Do you receive energy assistance? - - - - - - - - - ☐ **Yes** _____ (Type) ☐ **No**

Do your children have Medical Coverage? - - - - - - - ☐ **Yes** _____ (Type) ☐ **No**

Do you have Medical Coverage? - - - - - - - - - - - - - ☐ **Yes** _____ (Type) ☐ **No**

Are you under a doctor's care? - - - - - - - - - - - - - ☐ **Yes** ☐ **No**

Are you taking medications? - - - - - - - - - - - - - ☐ **Yes** ☐ **No**

Comments: _____

Do you feel you have a drug or alcohol problem? ☐ **Yes** ☐ **No**

Do you feel threatened or unsafe in your home? ☐ **Yes** ☐ **No**

Comments: _____

Do you have your high school diploma? - - - - - - - - - ☐ **Yes** ☐ **No**

Are any other members of your household a Veteran or Serving in the Military?
☐ **Yes** ☐ **No**

How can our program assist you? _____

Additional Comments:

_____

_____

_____

Notice: Hold Harmless Agreement

Please understand that The Plainville Community Food Pantry is a non-profit, referral service, which is simply acting as intermediary between sponsoring families and donors and families seeking assistance. As a result, we disclaim all liability, which may result from the consumption of food, or use of any donated item provided as a result of this application. This disclaimer includes, but is not limited to, any sickness, injury or death that may result from the receipt of goods or food or consumption of contaminated food, spoiled food, or tainted food, or other injury or death caused by the acts of the sponsor.

I have read the above Hold Harmless Agreement in its entirety and fully understand the same. I hereby agree to hold Plainville Community Food Pantry, its Officers, Director, Staff and Volunteers harmless from injury, illness or death that may result from the receipt, use, and/or consumption of the goods and food provided to me as a result of this application, in addition to any injury or death resulting from any acts of the sponsor.

_____ _____

Signature **Date**

Your Social Worker: _____ **Agency:**_____

I hereby certify that the above information is accurate and completely true in the account of my situation at this present time.

_____ _____

Signature **Date**

Household Breakdown

Name: ___________________________________ Soc. Sec. #: xxx-xx-______

Spouse/Roommate Name: _____________________ Soc. Sec. #: xxx-xx-_____

Optional: Race: ☐ White ☐ African American ☐ Hispanic ☐ Asian ☐ Other

ALL children in the household (under 18 years of age):	**Are you receiving any benefits for this child?**
Child's Name: _______________ D.O.B: _________ Age____Sex____	☐ Yes, **Agency__________ $_____** ☐ No
Child's Name: _______________ D.O.B: _________ Age____Sex____	☐ Yes, **Agency__________ $_____** ☐ No
Child's Name: _______________ D.O.B: _________ Age____Sex____	☐ Yes, **Agency__________ $_____** ☐ No
Child's Name: _______________ D.O.B: _________ Age____Sex____	☐ Yes, **Agency__________ $_____** ☐ No
Child's Name: _______________ D.O.B: _________ Age____Sex____	☐ Yes, **Agency__________ $_____** ☐ No
Child's Name: _______________ D.O.B: _________ Age____Sex____	☐ Yes, **Agency__________ $_____** ☐ No

ALL other adults in the household (Over 18 years of age):	**Is this person also seeking assistance?**
Name: ______________________ D.O.B: _________	☐ Yes ☐ No **Income $ ______/Mo.**
Name: ______________________ D.O.B: _________	☐ Yes ☐ No **Income $ ______/Mo.**
Name: ______________________ D.O.B: _________	☐ Yes ☐ No **Income $ ______/Mo.**

Other members of your household Vaccinated Yes___ No_____

Total number of veterans in household: ______ Total number of disabled in Household: ______

The above information is hereby accurate and true to the best of my knowledge and belief.

_______________________________________ _______________________

Signature **Date**

_______________________________________ _______________________

Spouse/Roommate Signature **Date**

This is to authorize Susie Woerz, Executive Director of the Plainville Community Food Pantry, the discretion to obtain, exchange, and/or release information concerning my history, finances, care, treatment, health and any other related information as it may apply for the sole purpose of my PCFP eligibility determination and/or Intervention and Referral purposes. By signing I understand that this application and the attached required documents become property of the Plainville Community Food Pantry and are subject to inspection at the discretion of the Executive Director.

_______________________________________ _______________________

Signature **Date**

This authorization may be revoked by me at any time, except to the extent that action has been taken in reliance thereon. This authorization, unless expressly revoked earlier, expires one (1) year from date signed.

Authorization for the Release of Records/Information

I, _____ hereby authorize the release of any or all of my personal information by the following parties:

HRA (Human Resources Agency)
School Social Worker
Department of Social Services Case Manager
Department of Children and Families Case Managers
Eversource Electric
Eversource Gas
HRA Case Manager
Youth Services
Plainville Social Services
Chrysalis Center
Wheeler Clinic
Klingberg
CMHA
Property Manager Name/Phone Number_____
_____
Landlord Name/Phone Number_____
_____
Other (Please Specify**):** _____

To Susie Woerz, Executive Director of the Plainville Community Food Pantry and Fuel Bank.

This consent applies to all types of information as described by the above name's records and is to be released for the purposes of the Pantry and/or Fuel Bank program Eligibility Determination. This consent will expire one (1) year from the date signed or sooner at my election.

_____ _____

Date **Signature**