**FAMILY NEEDS ASSESSMENT**

**APPLICANT INFORMATION**

PLEASE LIST ALL HOUSEHOLD MEMBERS: (Please print all information)

<table>
<thead>
<tr>
<th>RELATION (see legend below)</th>
<th>NAME</th>
<th>SSN</th>
<th>DOB</th>
<th>SEX</th>
<th>ETHNICITY (see legend below)</th>
<th>RACE (see legend below)</th>
<th>Please answer Y or N</th>
<th>Highest Grade Completed</th>
<th>Please answer Y or N</th>
</tr>
</thead>
<tbody>
<tr>
<td>SELF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Health Ins.</td>
<td>Veteran</td>
<td>Disabled</td>
</tr>
</tbody>
</table>

Any NON-US Citizens in this Family?

☐ Yes ☐ No

**Legend:**

**Relation to Applicant:**
- SP - Spouse
- CH - Child
- SC - Step-Child
- PA - Parent
- GP - Grand Parent
- GC - Grand Child
- RE - Related
- NR - Not Related
- SI - Sibling
- CH - Co-Head
- BF - Boyfriend
- GF - Girlfriend
- UN - Unknown
- OT - Other

**Ethnicity:**
- H - Hispanic or Latino
- N - Non-Hispanic or Latino

**Race:**
- BL - Black
- WH - White
- AS - Asian
- HA - Hawaiian or Other Pacific Islander
- AI - American Indian or Alaska Native
- UN - Unknown
- OT - Other
FAMILY NEEDS ASSESSMENT

CONTACT INFORMATION

Home Address: ________________________________

City: __________________________ State: FL Zip: ______

Mailing Address: ________________________________

City: __________________________ State: FL Zip: ______

Phone Numbers:

Home Phone: __________________________

Cell Phone: __________________________

Work Phone: __________________________

II. CRISIS

1. Briefly describe the crisis that caused you to apply for emergency assistance and what date did it begin: __________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

2. What service(s) are you applying for with Human Services? (Specify):

_________________________________________________________________

3. What is your plan for providing for your monthly expenses next month if you were not able to meet them this month?

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________
FAMILY NEEDS ASSESSMENT

HOUSEHOLD CHARACTERISTICS: (check one in each category)

Marital Status:
- [ ] Married & Living w/Spouse
- [ ] Married & Not Living w/Spouse
- [ ] Single
- [ ] Never Married
- [ ] Divorced
- [ ] Living Together
- [ ] Widowed
- [ ] Other

Family Type:
- [ ] Single Person
- [ ] Two Parent Household
- [ ] Single Parent (Female)
- [ ] Single Parent (Male)
- [ ] Two Adults (no children)
- [ ] Other

Housing Status:
- [ ] Literally Homeless
- [ ] Unstably Housed and At Risk of Losing Home
- [ ] Imminently Losing Home
- [ ] Stably Housed – Rent
- [ ] Stably Housed - Own
- [ ] Other

Housing Type:
- [ ] Rental (Single Family)
- [ ] Rental Unit (2-4 Unit Bldg.)
- [ ] Rental Mobile Home
- [ ] Own Mobile Home
- [ ] Own Home
- [ ] Shelter/Room/Dorm
- [ ] Homeless
- [ ] Other

1. Do you have relatives that work at Volusia County Human Services?
   - [ ] Yes   - [ ] No

2. If you answered yes, please give relative(s) name and position.

____________________________________________________

____________________________________________________
FAMILY NEEDS ASSESSMENT

FINANCIAL EVALUATION

INCOME:
1. Are you employed? ☐ Yes ☐ No
2. Any other Household members employed? ☐ Yes ☐ No
   Self: ___________________________ Monthly Income: $ ______________________
   Source of Income: ___________________________

   Family Member: ___________________________ Monthly Income: $ ______________________
   Source of Income: ___________________________

   Family Member: ___________________________ Monthly Income: $ ______________________
   Source of Income: ___________________________

   Total Household Monthly Income: $ ______________________

What assistance does your family receive? (Check all that apply)

<table>
<thead>
<tr>
<th>Assistance</th>
<th>Currently Receiving</th>
<th>Received in Past 90 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Support- Court Order No: __________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TANF - Amount: $_________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food Stamps- Amount: $_________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partnership for Workforce Development (PWD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 8/Public Housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Security - Amount: $_____________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSI/ SSD - Amount: $____________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment Compensation - Amount: $___________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worker's Compensation - Amount: $________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans Benefits - Amount: $__________________</td>
<td></td>
<td></td>
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<tr>
<td>WIC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pension</td>
<td></td>
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</tbody>
</table>

HOUSEHOLD EXPENSES:

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount: $_________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHELTER (Rent or Mortgage)</td>
<td></td>
</tr>
<tr>
<td>ELECTRIC</td>
<td></td>
</tr>
<tr>
<td>GAS</td>
<td></td>
</tr>
<tr>
<td>WATER</td>
<td></td>
</tr>
<tr>
<td>INSURANCE</td>
<td></td>
</tr>
<tr>
<td>MEDICAL</td>
<td></td>
</tr>
<tr>
<td>CAR PAYMENT</td>
<td></td>
</tr>
<tr>
<td>GAS FOR AUTO</td>
<td></td>
</tr>
<tr>
<td>CAB/BUS FARE</td>
<td></td>
</tr>
<tr>
<td>FOOD</td>
<td></td>
</tr>
<tr>
<td>CHILD CARE</td>
<td></td>
</tr>
<tr>
<td>CHILD SUPPORT</td>
<td></td>
</tr>
<tr>
<td>IRS</td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
</tr>
</tbody>
</table>

TOTAL HOUSEHOLD MONTHLY EXPENSES

For Human Services Use Only

Federal Poverty Percentage Level: __________ %
FAMILY NEEDS ASSESSMENT

DECLARATION

I hereby declare that the above information is correct to the best of my knowledge and belief. I authorize the County of Volusia to verify any information I have provided regarding my income by waiving my rights to privacy concerning such records. I fully understand that any information provided above, if proved incorrect or false will lead to my application being rejected and assistance denied for the remainder of the fiscal year. If it is determined after assistance is provided that I did not provide correct information future assistance will be denied for the remainder of the fiscal year. The County of Volusia fiscal year is from October 1st through September 30th.

I also give the County of Volusia permission to release any information on this Family Needs Assessment to agencies which I may be referred for assistance or services.

Social security numbers are unique numeric identifiers that are used by this office to identify, verify, track and search information in conjunction with an individual's application for assistance. The County of Volusia may disclose social security numbers to another agency or governmental entity if it is necessary for the receiving agency or governmental agency to perform its duties and responsibilities.

SIGNATURE OF APPLICANT

DATE

AUTHORIZED REPRESENTATIVE SIGNATURE
(if applicable)

DATE

RELATIONSHIP TO APPLICANT

CASE WORKER'S SIGNATURE

DATE

SUPERVISOR'S SIGNATURE

DATE
NOTICE REGARDING COLLECTION OF SOCIAL SECURITY NUMBERS
COMMUNITY SERVICES BLOCK GRANT PROGRAM

The following disclosure is being made pursuant to section 119.071(5), Florida Statutes.

Social security numbers of applicants and household members are requested because this information has been determined to be imperative for the performance of the duties and responsibilities prescribed by law under the Community Services Block Grant Program. This information is not required by state or federal law; however, social security numbers are necessary to determine eligibility for program services and specifically for the following purposes:

1. To verify an applicant's identity.
2. To verify household size.

A social security number collected pursuant to this notice can only be used by the Florida Department of Economic Opportunity and ______ County of Volusia______ (subgrantee) for the purposes specified above.

Nondisclosure except under limited circumstances.
Social security numbers will not be disclosed to others unless required or authorized by Florida law. Section 119.071(5), Florida Statutes, allows disclosure of a person's social security number under the following specific, limited circumstances:

- If disclosure is expressly required by federal or Florida law or is necessary for the agency or governmental entity to perform its duties and responsibilities;
- If the individual expressly consents to disclosure in writing;
- If disclosure is made to prevent and combat terrorism pursuant to the U.S. Patriot Act of 2001 or Presidential Executive Order 13224 (blocking property and prohibiting business transactions with persons who commit, threaten to commit, or support terrorism);
- For an agency employee and dependents, if disclosure is necessary to administer the person’s health benefits or pension plan funds; or
- If disclosure is for the purpose of the administration of the Uniform Commercial Code by the office of the Secretary of State.
- If disclosure is requested by a commercial entity for permissible uses under the federal Driver’s Privacy Protection Act of 1994, the federal Fair Credit Reporting Act, or the federal Financial Services Modernization Act of 1999 (for example, to verify the accuracy of personal information provided by the individual to the commercial entity; use by an insurer in connection with claims investigation or anti-fraud activities; for use in connection with a credit transaction).

Acknowledgment of Receipt of Notice
I confirm that I have been provided a copy of this Notice regarding the collection of my social security number and the social security numbers of all household occupants as part of the application process for the Community Services Block Grant Program.

________________________  _________________________
Date                        Applicant's Signature