COMMUNITY SERVICE OF NEWBURYPORT
since 1912

35 Summer Street
Newburyport, MA 01950
978-465-7562
Serving residents of Newbury, Newburyport and West Newbury

INTAKE APPLICATION FOR SERVICES

DATE 4/5/24 PRIMARY LANGUAGE English

PRIMARY APPLICANT/HEAD OF HOUSEHOLD_____DOB_____

ADDRESS _____TOWN/CITY_____

CELL#_____ HOME#_____ EMAIL_____

PHOTO ID DRIVERS LIC ___MA ID CARD____PASSPORT____OTHER____ PROVIDE VERIFICATION

EMPLOYMENT YES____NO____ NAME OF EMPLOYER_____

FULL TIME ____ PART TIME____ NET PAY $_____

MONTHLY INCOME/BENEFITS (TOTALS) (If reported weekly, multiply by 4.5)

SNAP _____ SSI/SSDI _____WIC _____ CHILD SUPPORT _____ PENSION_____ ALIMONY _____

VET BENEFITS ____ FUEL ASSISTANCE _____OTHER_____ PROVIDE VERIFICATION

TYPE OF RESIDENCY

OWN HOME ___RENT/LEASE ___SECTION 8 ___HOMELESS ___ AFFIDAVIT OF DOMICILE___
PROVIDE VERIFICATION

DO YOU HAVE HEALTH INSURANCE? MEDICAID ____ MEDICARE____ PRIVATE ____ PROVIDE VERIFICATION

DO YOU HAVE DENTAL INSURANCE? YES____ NO____ PROVIDE VERIFICATION

DO YOU HAVE CAR OR LEASED CAR PAYMENT? IF YES, MONTHLY AMOUNT $_____

DO YOU HAVE CREDIT CARD DEBT? IF YES, AMOUNT $_____

DO YOU/YOUR HOUSEHOLD RECEIVE SERVICES FROM ANY OF THESE ORGANIZATIONS?

____PENTUCKET EARLY INTERVENTION PROGRAM _____age(s) of child)ren
____COMMUNITY ACTION, INC.
____HEAD START_____age(s) of child(ren)
____TRANSITIONAL ASSISTANCE
____SALVATION ARMY
____JEANNE GEIGER CRISIS CENTER
____THE PETTENGILL HOUSE, INC.
____OUR NEIGHBORS' TABLE
____OPPORTUNITY WORKS
____PUBLIC SCHOOL FREE/REDUCED LUNCH _____age(s) of child(ren)
____SOCIETY OF ST. VINCENT de PAUL
____HOWARD BENEVOLENT SOCIETY
____GENERAL CHARITABLE SOCIETY OF NEWBURYPORT
____NEWBURYPORT SOCIETY FOR THE RELIEF OF AGED WOMEN
____GRIFFIN HOME FOR AGED MEN
____LINK HOUSE
____RESIDENCE FOR WOMEN IN RECOVERY
____PELICAN INTERVENTION FUND
____OTHER _____

ARE YOU A VETERAN OR ACTIVE MILITARY? YES_____ NO_____

ARE YOU DISABLED? YES_____ NO_____ IF YES, DIAGNOSIS_____

DOES ANY CHILD IN YOUR CARE USE DIAPERS? YES ____N0___ IF YES, WHAT SIZE(S)? _____

DOES ANYONE IN YOUR HOUSEHOLD USE ADULT INCONTINENCE PRODUCTS?
YES ___NO____ IF YES, WHAT SIZE(S)? _____

EMERGENCY CONTACT INFORMATION

NAME_____EMAIL_____

PHONE _____RELATIONSHIP_____

ADDITIONAL INFORMATION/NOTES _____

_____

_____**PRIMARY APPLICANT/HEAD OF HOUSEHOLD**

ADDITIONAL HOUSEHOLD MEMBER INFORMATION

First and Last Name		**Relationship to Applicant/ Head of Household**
2. _____ Gender Identity___Vet/ActMilitary_____ Disabled_____Diagnosis_____	**DOB** _____ **AGE**	____Spouse ____Significant Other ____Dependent ____ Parent ____Relative ____Non-Relative
3. _____ Gender Identity_____Vet/Act Military____ Disabled_____Diagnosis_____	**DOB** _____ **AGE**	____Spouse ____Significant Other ____Dependent ____ Parent ____Relative ____ Non-Relative
4. _____ Gender Identity_____Vet/Act Military____ Disabled_____Diagnosis_____	**DOB** _____ **AGE**	____Spouse ____Significant Other ____Dependent ____ Parent ____Relative ____ Non-Relative
5. _____ Gender Identity_____Vet/Act Military____ Disabled_____Diagnosis_____	**DOB** _____ **AGE**	____Spouse ____Significant Other ____Dependent ____ Parent ____Relative ____ Non-Relative

Please use a separate sheet for additional household members.

I hereby declare that the above statements are true to the best of my knowledge.
I understand I must provide verification before Community Service of Newburyport can provide services.

SIGNATURE OF APPLICANT_____ DATE_____

PRINT YOUR NAME_____

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FOR OFFICE USE ONLY: (PLEASE MAKE PHOTOCOPIES**)**

___**PHOTO ID VERIFICATION** W/ DRIVERS LICENSE, MA IDENTIFICATION CARD, OR PASSPORT

___**MONTHLY INCOME/BENEFITS**

___**RESIDENCE VERIFICATION** W/MORTGAGE PAYMENT, RENTAL AGREEMENT, UTILITY BILL IN YOUR NAME, OR AFFIDAVIT OF DOMICILE

___**HEALTH INSURANCE**

___**DENTAL INSURANCE**

___**SIGNED RELEASE(S) OF INFORMATION**

___**GIVEN RACK CARD**

Intake Completed by: _____Title _____Date_____
(Staff's Full Name)