



FAMILY NEEDS ASSESSMENT (FY 14-15)

APPLICANT INFORMATION

PLEASE LIST ALL HOUSEHOLD MEMBERS: (Please print all information in black or blue pen only)

RELATION (see legend below)	NAME	SSN	DOB	SEX	ETHNICITY (see legend below)	RACE (see legend below)	Please answer Y or N				Highest Grade Completed	Please answer Y or N	
							Health Ins.	Veteran	Disabled	Currently In School?		Migrant Farm Worker	Seasonal Farm Worker
SELF													

Any NON-US Citizens in this Family?

☐ Yes ☐ No

Legend:

Relation to Applicant:

SP – Spouse	NR - Not Related
CH – Child	SI - Sibling
SC - Step-Child	CH - Co-Head
PA – Parent	BF – Boyfriend
GP - Grand Parent	GF – Girlfriend
GC - Grand Child	UN – Unknown
RE - Related	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



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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?



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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.



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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)	Currently Receiving	Received in Past 90 days
Child Support- Court Order No: _____ State: _____ Amount: \$ _____		
TANF – Amount: \$ _____		
Food Stamps- Amount: \$ _____		
Medicaid		
Medicare		
Partnership for Workforce Development (PWD)		
Section 8/Public Housing		
Section 8 Utility Reimbursement Amount: \$ _____		
Social Security – Amount: \$ _____		
SSI/ SSD – Amount: \$ _____		
Unemployment Compensation – Amount: \$ _____		
Worker's Compensation – Amount: \$ _____		
Veterans Benefits – Amount: \$ _____		
WIC		
Pension Type: _____ Amount: \$ _____		

HOUSEHOLD EXPENSES:

SHELTER (Rent or Mortgage)	
ELECTRIC	
GAS	
WATER	
INSURANCE	
MEDICAL	
CAR PAYMENT	
GAS FOR AUTO	
CAB/BUS FARE	
FOOD	
CHILD CARE	
CHILD SUPPORT	
IRS	
OTHER	
TOTAL HOUSEHOLD MONTHLY EXPENSES	

For Human Services Use Only

Federal Poverty Percentage Level: %



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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

or

**AUTHORIZED REPRESENTATIVE SIGNATURE
(if applicable)**

DATE

RELATIONSHIP TO APPLICANT

.....

CASE WORKER'S SIGNATURE

DATE

SUPERVISOR'S SIGNATURE

DATE