OHC
OUR HEALTHY COMMUNITIES

PARTICIPANT INTAKE FORM
OUR HEALTHY COMMUNITIES, INC.
506 E Spruce / PO Box 778
Rogers, AR 72757
PH: 479-636-7301 FAX: 479-636-7312

Today's Date

PLEASE COMPLETE THE ENTIRE FORM

Social Security #	First Name	MI	Last Name	Birth Date (mm/dd/yyyy)	Age	Gender	Disabled
- -						☐Male ☐Other ☐Female	☐Yes ☐ No

Address	City	State / Zip	Home #	Cell #

Race (Select One)		Ethnicity	Education		Work Status	Health Coverage	Veteran Status
☐ White ☐ Black ☐ Asian ☐ Other	☐ Pacific Islander or Native Hawaiian ☐ American Indian or Alaska Native ☐ Multi Race	☐ Hispanic or Latino ☐ NOT Hispanic	☐ 0 to 8th Grade ☐ 9th - 12th Grade (non-grad) ☐ High School Grad/GED	☐12+ Post Secondary ☐ College Graduate 2 or 4 year ☐ Graduate other Post Secondary School	☐ Youth 14-24 Not Working or in School ☐ Employed Full Time ☐ Employed Part Time ☐ Migrant Worker ☐ Unemployed 6 Months or Less ☐ Unemployed 6 Months or More ☐ Unemployed Not Working ☐ Retired	☐ Medicare ☐ Medicaid ☐ State Health Insurance Children ☐ State Health Insurance Adults ☐Military Health Insurance ☐ Employment Based ☐ No Insurance	☐Yes ☐ No ☐Active Duty

Name	Amount per Month	Income Source (Select Letter)
	$	
	$	
	$	
	$	
Do you Received Snap Benefits ☐ Yes ☐ No	$	
Total Household Income	$	

Write the letter that corresponds with the income in the Income Source box for each individual

A TANF
B SSI-Social Security
C SSD-Disability
D VA Service - Disability
E VA Non service - Disability
F Private Disability Insurance
G Workers Compensation
H Retirement from Social Security
I Pension
J Child Support
K Alimony or other spousal support
L Employed – Full Time or Part Time
M Self Employed
N Unemployed
O Other **(Describe)**

Staff Use only: Sources Verified: ____ Staff Initials: _____

Income Verified: ____ Corrected Amount $_____

Household Type (Select One)		Household Size	Housing	
☐ Single Person ☐ Two Adults, No Children ☐ Single Parent Female ☐ Single Parent Male ☐ Two Parent Household	☐ Non Related Adults with Children ☐ Multigenerational Household ☐ Other	☐ Single Person ☐ Two ☐ Three ☐ Four ☐ Five ☐ Six or more	☐ Own ☐ Rent ☐ Other Permanent Housing ☐ Homeless ☐ Other	

LIST ALL OTHER MEMBERS OF THE HOUSEHOLDS – DO NOT INCLUDE YOURSELF HERE:
If you need additional space please request another intake form.

Name (PLEASE PRINT)	Social Security #	Birth Date	Age	Relationship to Applicant	Gender	Race (See Front Page for Options)	Hispanic or Latino	Disabled	Health Insurance	Type of Health Coverage (See Front Page for Options)	Education (Highest Grade Completed)
1.	_____-____-_____				M / F		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
2.	_____-____-_____				M / F		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
3.	_____-____-_____				M / F		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
4.	_____-____-_____				M / F		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
5.	_____-____-_____				M / F		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		

OHC, Inc. receives funding from various sources and is required to provide these funding sources with statistical data on the clients we serve.
YOUR PERSONAL INFORMATION IS KEPT STRICTLY CONFIDENTIAL.

I understand that disclosure of the above information is voluntary and will be used only for statistical purposes. The data compiled with other households will be used to create reports for OHC's funding sources.

I certify that the income and other information provided on this form is correct at the time of this application.

Applicant Signature: _____ **Email Address**: _____ **Date Signed:** _____

LIHEAP H2O CASE MANAGEMENT COVID-19

APPROVED DECLINED REASON FOR DENIAL