Client Name (First): _____ Last: _____ DOB: _____

mama's kitchen

Mama's Kitchen Referral Emergency Financial Assistance (EFA) – Nutrition Support

Program Description: Up to 12 non-perishable food bags in a 12-month period, provided through an approved EFA distribution site. Food bags will make up to 21 meals, or 1 week of groceries.

✳1. CLIENT DEMOGRAPHIC INFORMATION

✳First Name	✳Last Name	✳Phone	✳Language

✳Address	✳City	✳Zip	✳Date of Birth	✳Age

✳Gender:	☐ Female ☐ Male ☐ Transgender (MTF) ☐ Transgender (FTM) ☐ Nonbinary ☐ Other: _____
✳Race:	☐ White ☐ Black/African American ☐ Asian/Asian American ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Black/African American & White ☐ American Indian/Alaska Native & White ☐ Asian & White ☐ American Indian/Alaska Native & Black ☐ Prefer not to answer
✳Ethnicity:	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer

✳Have you ever served in the US Military? ☐ Yes ☐ No	✳Living Arrangement: ☐ Client owned ☐ Rental ☐ Friends/Relatives ☐ Transitional/Hotel ☐ Emergency ☐ Unsheltered

✳2. DIAGNOSIS ELIGIBILITY

☐ **HIV/AIDS**; ICD10: B20 ✳ *HCC release* update in HCC/attached required	✳**HCC ID#:**

✳11. CLIENT or HEAD OF HOUSEHOLD (HOH) INCOME DECLARATION

The following is required for all clients due to grant and government funding requirements, however it does not affect eligibility for services with Mama's Kitchen. *Gross annual income must include all sources of income (wages, child support, SSI, unemployment, pension, income from assets, etc., but does not include the income of live-in aides, per 24 CFR 5.403). **Depending on program requirements, you might be asked for additional documentation.**

✳My total family size consists of		✳ **members**
✳The total gross income* for all adult members is	$	✳ **monthly**

I certify that the information given on this form is complete and accurate to the best of my knowledge. I certify that I am at least 18 years of age or older. I am aware of the penalties for willfully and knowingly giving false information on an application for federal funds, which may include immediate cease of services and/or legal proceedings. I understand that the information on this form is subject to review by Mama's Kitchen staff and program funders as part of compliance monitoring only.

✳ **Client Signature**	✳**Client Printed Name**	✳**Date**

✳3. CASE MANAGER SIGNATURE & VERIFICATION OF EMERGENCY

✳**Authorizing Provider Signature: Provider's signature below certifies that applicant is eligible, the required documentation (letter of diagnosis and proof of income) is on file in HCC and all other resources and methods of payment for applicant have been exhausted so that Ryan White Treatment Extension Act will be the payer of last resort.**

✳Using the stated monthly income above, what is the amount that is owed or outside the normal budget?	$_____ . _____
✳Check the reason for emergency food assistance	☐ Extra expenses ☐ Loss of Income/Benefit
✳Additional Details: (e.g. loss of SNAP, WIC, other qualifying event)	
✳How will the client live within their budget moving forward? Check all that apply.	☐ Client has created a budget with RW CM and will review monthly ☐ Client has identified 2 local food banks that they will visit on scheduled days and times for distribution ☐ Other:

✳**Print CM First Name**	✳**Print CM Last Name**	✳**CM Email Address**	✳**CM Phone Number**

X

✳**Case Manager Signature**	✳**Date Signed**	✳**Agency Name**