

To request help for a critical need, please complete the intake form, request form, and provide copies of the following (not originals):

- Proof of income for all household members: 4 consecutive weeks of paystubs/SS award letter
- Specific documentation of need: invoice, estimate, termination letter, etc.
- For vehicle requests only: driver's license, vehicle title, insurance, and registration

Please mail the intake form, request form, and copies to the address below. You can also drop off the documentation in-person during normal office hours, or by using our after-hours drop off (at the top of the long ramp). Please put all copies in an envelope marked Family Services.

Lewis County Opportunities, Inc.
Family Services Department
8265 State Route 812
Lowville, NY 13367

After all information has been received, a Family Services Worker will be in touch. This does not guarantee that you will receive assistance. If you have any questions, please stop in during our normal business hours (Monday-Friday, 8am-4pm) or call us at 315-376-8202. We look forward to working with you!

Sincerely,

Family Services Department



**Lewis County Opportunities, Inc.
Consumer Intake Form**

Application # _____

Applicant Name _____

Mailing Address _____

Physical Address _____

Phone Number _____

Email Address _____

SS# _____

Source of Income (Please circle all that apply)

No income	Employment	TANF	PA	OTDA SSP	SSI	SS Disability	SS Retirement
Worker's Comp	Private Disability Insurance	Pension	Int/Divid	Child Support	EITC	Alimony	Unemployment
VA Disability	VA Non-Service Pension	Rental	Self- employment	Other: _____			

Non-Cash Benefits (Please circle all that apply)

SNAP	WIC	HEAP	Housing	HUD/VASH	Permanent Supportive Housing
Public Housing	Child Care Voucher	Affordable Care Act Subsidy	None	Other: _____	

Housing (Please circle one choice)

Own	Rent	Homeless	Other Permanent	Other: _____
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Reliable Transportation (Please circle all that apply)

Yes	No	Public Transportation	Friends/Family	Bicycle
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Household Type (Please circle one choice)

Single Parent- Female	Single Parent- Male	2 Parent	Single Person	2 Adults/No Children	Non-related Adults w/ Children
Multi- Generational	Other: _____				

Household Income Verification (Please complete for all members receiving income)

Member	Amount	Interval (Weekly, Biweekly, Semi-Monthly, Monthly, Semi-Annual, Annually, Quarterly, Other- explain)

Household Members (Please complete for all members in the household- use codes below chart)

Member	Sex	Relation	Marital Status	Date of Birth	Ethnicity	Race	ED	DY	EM	Disabled Y/N	Ins	Military
		Self										

Sex: M (Male), F (Female), X (Other)

Relation: SP (Spouse), CH (Child), PA (Parent), PN (Partner), OT (Other)

Marital Status: CH (child), DI (Divorced), MA (Married), SE (Separated), SI (Single), WI (Widowed)

Ethnicity: HIS (Hispanic/Latin), NON (Non-Hispanic/Latin)

Race: WH (White/Caucasian), BL (Black/African American), MR (Multirace), OTH (Other), AI (American Indian/Alaska Native), NH (Native Hawaiian/Pacific Islander), AS (Asian)

ED- Education: 0-8 (Grade 0-8), 12NON (9-12 non-graduate), HSG (High school graduate), GED (GED), 12+ (Some further education), VS (Vocational school), 2YR (Associate Degree), 4YR (Bachelor Degree)

DY- Disconnected Youth (under 24): IS/NW (In school, not working), IS/W (In school, working), NW/NIS (Not working, not in school), W/NIS (Working, not in school), >24 (Over 24), UK (Unknown)

EM- Employment: FT (Full-time), PT (Part-time), SF (Migrant Seasonal Farmer), US (Unemployed short term *less than 6 months), UL (Unemployed long term *more than 6 months), U (Unemployed *not in workforce), R (Retired)

INS- Insurance: N (No Insurance), MD (Medicaid), ME (Medicare), SC (State Children’s Health), SA (State Adult Health), MH (Military Health), D (Direct Purchase), EM (Employment-based)

Military: N (Non-Military), A (Active Military), V (Veteran)

****If being completed by consumer****

I certify that the above information is true and accurate to the best of my knowledge.

Name (Signature): _____

Date: _____



Critical Needs Request

Name _____

Phone Number _____

Please answer the following in as much detail as possible. Return this page with the copies requested on the information sheet. Thank you!

- 1. What is your specific need?** Transportation - *vehicle repair, insurance or vehicle loan*
 EF&S - *emergency utilities, mortgage or rent assistance*
 Critical Needs - *clothing, household items and/or linens*
 Stewarts - *beds for children (Under 18)*
 Other - _____

2. How much can you put toward this need? \$ _____

3. What has caused this need? _____

4. How would your situation improve if this need was met? _____

Monthly Expenses Worksheet



Income	Amount
Wages, Salary, Unemployment, TANF	
Social Security Benefits (SSI/SSA/SSP/SSDI), Disability Benefits	
Alimony and/or Child Support Received, Foster Care Support	
Pension, VA Benefits, Worker's Compensation	
Interest, Investment, Hobby Income	
Other Sources of Income	
Total	
Income Taxes Paid Out	

Support Services Income	Amount
Housing	
SNAP	
HEAP	
WIC	
Total	

Net Income	
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Home	Amount
Mortgage/Rent	
Home/Renters Insurance	
Repairs/Maintenance (pest control, Lawn care, etc.)	
Taxes	Land
	School
	Village
Total	

Transportation	Amount
Vehicle Loan - 1	
Vehicle Loan -2	
Public Transportation (Bus Pass, VTC, etc.)	
Insurance	
Vehicle Gas	
Repairs/Maintenance	
Total	

Utilities	Amount
Water/Sewer	
Propane Stove	
Heating Cost (Oil, Kerosene, Propane, Wood, Natural Gas)	
Trash Removal	
Electric Bill	
Internet, TV, Phone	
Cell Phone Bill	
Total	

Family Expenses	Amount
Child Care/Support/Alimony	
Educational Expenses	
Entertainment (Streaming Services/Subscriptions)	
Activities/Lessons/Hobbies	
Laundry Mat/Clothing/Shoes	
Pet Care/Food	
Allowances	
Total	

Grocery/Personal	Amount
Food	
Household Items/Supplies	
Personal Care Items	
Eating Out	
Medications (Scripts/OTC)	
Total	

Other Expenses	Amount
Personal Loans	
Credit Card(s)	
Student Loans	
Deposit into Savings	
Medical Bills/Insurance Premiums	
Total	

Net Income	
Bills Total	
Amount Left Over	