BRITEPATHS APPLICATION FOR FOOD BRIDGE PROGRAM

CLICK HERE to Learn More About This Program
Please read form carefully and fill out all of the requested information.

PLEASE NOTE: During the referral process, Britepaths staff may ask for additional information and documentation, including proof that the client resides at the stated address, a pay check stub, driver's license, etc. The information we are requesting is vital to our ability to assess whether the client qualifies for services, and is also necessary for our County reporting requirements. If you feel that you are not able to request and provide this information from the client, Britepaths recommends that you ask the client to contact Coordinated Services Planning (CSP) at 703-222-0880 to seek a referral.

Food Bridge: Clients must be participating in Britepaths' Financial Mentoring or similar program from another organization. Britepaths' Food Bridge Program is offered with the intention of helping the client to reduce debt. With lower grocery bills, we hope the extra funds they save could help their financial situation.

1. **I certify that I am a social worker or case worker, have met with or spoken at length with the client whose information I am submitting.**

   ____ Yes ____ No

2. **I vouch that I have seen documentation from this client, including proof of residency in Fairfax County, and proof of employment, benefits and other necessary documentation that allows me to verify the information on this form.**

   ____ Yes ____ No

Social Worker/Case Worker Name: **Phone:** **Email:**

Referring Agency: _____

Client Information

Client's First and Last Name: **Date of Referral:** _____
Client Date of Birth: _____

Full Address, Including City, State, Zip and Apartment # if applicable:

Primary Phone (Indicate Home/Cell): **Work Phone:** **Email:**

Marital Status:	**Ethnic Background:** ☐ **Hispanic** ☐ **Non-Hispanic**	**Head of Household**
___ **Married** ___ **Separated** ___ **Single**	**Race:** ☐ **White** ☐ **Middle Eastern** ☐ **Native American**	☐ **Female**
___ **Divorced** ☐ **Widowed**	☐ **African American** ☐ **Asian/Pacific Islander** ☐ **Other**	☐ **Male**

Client Receives:

TANF	**Section 8**	**SSI Disability**	**Food Stamps**	**Other Assistance**	**Head of Household Has Health Insurance**
$_____	☐ **Yes**	**$**_____	**$**_____	**$**_____	☐ **Yes** ☐ **No**

Employed? ☐ **Yes** **Income: $**_____ **Other Income (i.e. child support): $**_____

Income Level: (Check one)

☐ **Extremely Low Income** ☐ **Low Income**
☐ **Very Low Income** ☐ **Exceeds Income**

Household Size	Extremely Low Income	Very Low Income	Low Income
1	$25,500	$42,500	$54,350
2	$29,150	$48,550	$62,100
3	$32,800	$54,600	$69,850
4	$36,400	$60,650	$77,600
5	$39,350	$65,550	$83,850
6	$42,250	$70,400	$90,050
7	$45,150	$75,250	$96,250
8+	$48,050	$80,100	$102,450

BRITEPATHS APPLICATION FOR FOOD DELIVERY PROGRAM

Description of Need

Describe the crisis the client is experiencing. ***Must be temporary in nature to qualify for this Program.***

Describe what kind of guidance and services the client is receiving to work towards becoming self-sufficient:

Is the client willing to attend a free class on budgeting and/or Britepaths free Financial Counseling Clinic? Visit our Financial Literacy page.

Yes ___ No ___ (*If no, please provide client's explanation.*)

What other nonprofits or resources is client receiving assistance from? Has client applied for Food Stamps or other government benefits?

Is client in a stable living situation to received food delivery for the next six months?

Does client speak enough English to be able to communicate with Britepaths staff? If client does not speak English, what language does she/he speak. ***If other than Spanish, please provide name and number of a contact who can help us communicate with them, if at all possible.***

Britepaths offers emergency food to clients on our waitlist. If client is accepted for this program, will he/she be able to come to Britepaths to receive food if needed? ___ Yes ___ No. ***Britepaths's office hours are Monday-Friday, 10 a.m. to 2 p.m.***

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First Name _____ **Last Name** _____

Number in Household:

Women:_____ **Men:**_____ **Girls:**_____ **Boys:**_____ **Handicapped:**_____ **Elderly:** _____

Client Family Members

#	Family Member Name	Birth Date	Sex	Relationship	Has Medical Insurance (Y/N)
1	First: Last (If different)		☐ Female ☐ Male	☐ Spouse ☐ Relative ☐ Child ☐ Non-Relative	
2	First: Last (If different)		☐ Female ☐ Male	☐ Spouse ☐ Relative ☐ Child ☐ Non-Relative	
3	First: Last (If different)		☐ Female ☐ Male	☐ Spouse ☐ Relative ☐ Child ☐ Non-Relative	
4	First: Last (If different)		☐ Female ☐ Male	☐ Spouse ☐ Relative ☐ Child ☐ Non-Relative	
5	First: Last (If different)		☐ Female ☐ Male	☐ Spouse ☐ Relative ☐ Child ☐ Non-Relative	
6	First: Last (If different)		☐ Female ☐ Male	☐ Spouse ☐ Relative ☐ Child ☐ Non-Relative	
7	First: Last (If different)		☐ Female ☐ Male	☐ Spouse ☐ Relative ☐ Child ☐ Non-Relative	
8	First: Last (If different)		☐ Female ☐ Male	☐ Spouse ☐ Relative ☐ Child ☐ Non-Relative	
9	First: Last (If different)		☐ Female ☐ Male	☐ Spouse ☐ Relative ☐ Child ☐ Non-Relative	
10	First: Last (If different)		☐ Female ☐ Male	☐ Spouse ☐ Relative ☐ Child ☐ Non-Relative	