

BRITEPATHS APPLICATION FOR FOOD SUPPORT 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.

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

Food Support: Referred clients in a crisis situation can come to Britepaths to pick up an emergency food packing of non-perishable food and toiletries. The toiletries include laundry detergent, toilet paper, shampoo, diapers, etc. They will also receive a grocery gift card. If necessary, they may pick up a second packing two weeks later. These packings would provide a reprieve while they are working with their social worker to stabilize their situation.

Social Worker/Case Worker Name:

Phone:

Email:

Referring Agency: _____

Client Information

Date of Referral: _____

Client's First and Last Name: _____

Client Date of Birth: _____

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

Primary Phone (Indicate Home/Cell): _____

Work Phone: _____

Email: _____

Marital Status: ___ Married ___ Separated ___ Single ___ Divorced <input type="checkbox"/> Widowed	Ethnic Background: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	Head of Household <input type="checkbox"/> Female <input type="checkbox"/> Male
	Race: <input type="checkbox"/> White <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Native American <input type="checkbox"/> African American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other	

Client Receives:

TANF	Section 8	SSI Disability	Food Stamps	Other Assistance	Head of Household Has Health Insurance
\$ _____	<input type="checkbox"/> Yes	\$ _____	\$ _____	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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 the client's intervention plan:

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?

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.*

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

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First Name _____	Last Name _____
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Number in Household:					
Women: _____	Men: _____	Girls: _____	Boys: _____	Handicapped: _____	Elderly: _____

Client Family Members					
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#	Family Member Name	Birth Date	Sex	Relationship	Has Medical Insurance (Y/N)
1	First: Last (If different)		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative	
2	First: Last (If different)		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative	
3	First: Last (If different)		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative	
4	First: Last (If different)		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative	
5	First: Last (If different)		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative	
6	First: Last (If different)		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative	
7	First: Last (If different)		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative	
8	First: Last (If different)		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative	
9	First: Last (If different)		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative	
10	First: Last (If different)		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Non-Relative	