For office use only:	Date/Time Field:_____	Entered by (Staff Name):_____	☐CAP60	☐MCC

Program Manager
Angelina Reyes
608-314-4825

Merrill Community Center
A program of Community Action

Program Director
Elizabeth Knapp-Spooner
608-313-1336

Documents needed BEFORE enrollment:	**MCC**
☐Social Security Card ☐Birth Certificate ☐State ID/Driver's Lic. ☐Proof of Address ☐Income Verification	**Senior Program**

Senior Program 2023-2024

Census Tract_____

Date: _____ Date of Birth: _____Social Security Number: _____

First Name: _____Last Name: _____

Address: _____ ☐Rent ☐Own
House Number Street Name City State Zip

Gender: ☐Male ☐Female ☐Other-Please Specify: _____

Primary Phone: _____Secondary Phone: _____

Email: _____

County of Residence: _____ How long have you lived in this county: _____

Active Military: ☐Yes ☐No Veteran: ☐Yes ☐No Household Size: _____

Are you, or have you ever been, homeless: ☐Yes ☐No

If yes, when and for how long: *(list every time you have been without housing):*

Have you ever been evicted: ☐Yes ☐No
If yes, was it due to any illegal activities or actions: ☐Yes ☐No

Household Type (Please check one):

☐Single Adult ☐Divorced ☐Widowed
☐Married with Children ☐Married without Children ☐Legally Separated
☐Married without Children ☐Married with Children ☐Single Parent *(No spouse/partner in house)*

Race (Please check one):

☐White ☐Black or African American ☐Multi-Racial
☐White/Asian ☐Black/African American & White ☐Native Hawaiian/Other Pacific Islander
☐Asian ☐American Indian or Alaskan Native/Black ☐American Indian or Alaska Native
☐Don't Know:
Other: _____

Ethnicity (Please check one):

☐Hispanic ☐non-Hispanic

Education:

What is your highest level of education: ☐Non-HS Grad/No GED ☐HS Grad/GED
☐Some College ☐College Graduate

Are you currently in any schooling (HS, GED program, tech school, etc.): ☐Yes ☐No

Employment:

Are you currently employed: ☐Yes ☐No
If yes, what is the name of your current employer: _____
Employer Phone Number: _____
Address: _____
Number Street City State Zip
Job Title: _____ Wage per hour: _____ Avg. Hours per week: _____
Frequency of Pay: ☐Weekly ☐Bi-weekly ☐Monthly ☐Semi-Monthly ☐Quarterly ☐Annually

If you are currently unemployed, When did you last work?

Income:

Other Sources of Income (Please check all that apply, and supply the amount):

☐Unemployment $____ ☐Pension $____ ☐Social Security Retirement $____
☐Worker's Compensation $____ ☐Veteran's Pension $____ ☐Supplemental Security (SSI) $____
☐Alimony/spousal support $____ ☐Veteran's Disability $____ ☐Social Security Disability (SSDI) $____
☐Child Support $____ ☐Veterans Compensation $____ ☐TANF (W-2) $____
☐School Lunch ☐General Assistance

Total annual household income: _____Staff use only: Income percentage_____

Did you receive any of the following non-cash benefits in the last 30 days? (Please check all that apply, and supply amount)

☐Food Stamps $____ ☐Daycare Voucher $____ ☐WIC
☐Medicaid ☐Medicare ☐Badger Care
☐TANF Transportation Services $____ ☐Other TANF Funded Services$____ ☐Temporary Rental Assistance $____
☐ LIHEAP $____ ☐Other: _____

Do you need referrals for assistance applying for any of the non-cash benefits? ☐Yes ☐No
Referrals:
1._____
2._____
3._____
4._____

Health:
Do you currently have medical insurance, other than Medicaid/Medicare: ☐Yes ☐No
If yes, check all that apply:
☐Cobra ☐Private Pay/Direct Purchase ☐State Children's Health Insurance Program (CHIP)
☐Employer Provided ☐Indian Health Insurance ☐VA Medical Services/Military
☐Choose Not to Respond ☐Other: _____
Emergency Contact Name: _____ **Relationship**: _____
Phone Number: _____

Are you a victim of domestic violence: ☐Yes ☐No
If yes, how long ago: (Please check one)
☐Within the past 3 months ☐3-6 months ago ☐6-12 months ago ☐More than 1 year ago
☐Don't Know ☐Refuse to Answer

Do you have any long-term disabilities: ☐Yes ☐No
If yes, check all that apply:
☐Alcohol Abuse ☐Mental Health Concerns ☐Chronic Health Condition
☐Drug Abuse ☐Cognitive Disability ☐Hearing Impaired/Deaf
☐Alcohol and Drug Abuse ☐Developmental Disability ☐Visual impairment
☐Orthopedic ☐Short-term physical health condition ☐Choose Not to Respond
☐Other: _____

Household Information:
Number of people in household: _____

First & Last Name (as it appears on birth certificate):

Gender: _____
Date of Birth (mm/dd/yyyy): _____ ☐Grade: _____ Additional Income _____

First & Last Name (as it appears on birth certificate):

Gender: _____
Date of Birth (mm/dd/yyyy): _____ ☐Grade: _____ Additional Income _____

First & Last Name (as it appears on birth certificate):

Gender: _____
Date of Birth (mm/dd/yyyy): _____ ☐Grade: _____ Additional Income _____

MEDICAL TREATMENT: I give my permission for CAI staff members to administer first aid treatment or allow a physician or hospital to administer emergency treatment to my child as deemed necessary.

RELEASE OF LIABILITY: I will not hold CAI responsible in case of any loss, damage, injury, or death resulting from use of CAI facilities or participation in CAI activities either at or away from CAI.

_____I received Child Support information and referral Documentation.

_____I received Compliance /Grievance Process information.

_____I received Permission General Release of Information: I give permission for Information to be shared with partner organizations.

_____I received Photo/Media release information: I give permission for my photo/media to be used.

CERTIFICATION AND ACKNOWLEDGEMENTS

I certify that the information on this application is a true and complete statement of facts according to my best knowledge and belief. I also understand that I may be asked to provide proof of any information given on this application.

Applicant Signature: _____ Date: _____

Staff Signature: _____ Date: _____