Community Support & Nutrition Program (CSNP)

Referral Form

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | | | |  | | Date: | |  |  |
|  |  | | | |  | |  | |  |  |
| Referring Agency: |  | | | |  | | Phone: | |  |  |
|  |  | | | |  | |  | |  |  |  |
| Case Manager: |  | | | |  | | Ext: | |  |  |  |
|  |  | | | |  | |  | |  |  |  |
|  |  | | | |  | |  | |  |  |  |
| Client Name: |  | | | |  | | Client Ph: | |  |  |  |
|  |  | | | |  |  | | |  |  |  |
| Client Address: |  | | | | | | | | |  |  |
|  | Street |  |  |  | | | | | |  |  |
|  |  |  |  |  |  | | |  | | |  |
|  | City |  | State |  | Zip | | | | | |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Age: |  | |  | D.O.B. | |  | |  | Employed: | | | Yes: ☐ No: ☐ | | | | SSN: | XXX-XX- | | | | (last 4 digits only) | |
|  | |  | | |  | |  | | | |  | |  | |  | | |  | |  | |  |
| Client Pick Up: | | | | Yes: ☐ No: ☐ | | | or | | | Homebound Delivery: | | | | Yes: ☐ No: ☐ | | | | |  |  | |  |
|  | |  | | |  | |  | | | (See Qualifications on Reverse Side if Answered Yes) | | | | | | | | | | | | |

Consent:

I consent to the exchange of information between the above named agencies regarding my request for services

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Signature: |  | | |  | Date: | |  |  | |
|  | |  |  | | |  | | |  |

Other Household Members:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: (First, MI, Last) | Relationship: | Age: | DOB: | Employed? |
|  |  |  |  | Yes: ☐ No: ☐ |
|  |  |  |  | Yes: ☐ No: ☐ |
|  |  |  |  | Yes: ☐ No: ☐ |
|  |  |  |  | Yes: ☐ No: ☐ |
|  |  |  |  | Yes: ☐ No: ☐ |

Totals:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| # of Adults: | 2 |  | # of Children: | 0 | (under the age of 18) |  | Total # in Household: | 2 |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Income  Information | Source: | Applicant: | Other Members: | Total: |
| SSI/SSA/Social Security: | $ | $ | $ |
| SSID: (Disability) | $ | $ | $ |
| Food Stamps: (FNS) | $ | $ | $ |
| Unemployment: | $ | $ | $ |
| Alimony/Child Support: | $ | $ | $ |
| All Other Income: | $ | $ | $ |
| Total: | $ | $ | $ |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client is referred to the following Classes: | | | | | |  |  |  |  | |
| Nutrition Education: | ☐ |  | Nutrition Budgeting: | ☐ |  | Financial Capabilities: | ☐ |  | Job Readiness: | ☐ |

Community Support & Nutrition Program

Homebound Delivery Program

Purpose: To meet the needs of Guilford County’s homebound population with grocery assistance.

Qualifications: 1) Prospective clients must meet the financial guidelines issued by TEFAP (The Emergency

Federal Assistance Program).

2) Prospective clients should live in a single-person family household.

3) Prospective clients must be disabled, have a debilitating health issue, or severe circumstance

which makes it difficult for him/her to pick up their grocery assistance from the Program

office. If the prospective client has an aide, caretaker, or case manager that provides

transportation for the client or can pick up the assistance for the client, then that client is

not eligible for the homebound delivery program.

4) Prospective clients will provide appropriate verification to the referring agency and complete

all required forms of OSF’s Community Support & Nutrition Program.

Benefits: Approved clients will receive grocery assistance one time per month.

This occurs on the 3rd Tuesday of each month between the hours of 9am-5pm.

Clients placed on a homebound delivery route can be changed to regular pick up from the Program office, with proper advance notice. Homebound delivery can be short term or long term.