SCFS CARES ACT PROJECT

Applicant: ________________________________ **Date:**_________________

Address:____________________________ **Date of Birth:**_____________________________

City:___________**State:**____**Zip:**_______ **Gender:**________**Ethnicity:**_________________

Email:_______________________________ **Marital Status:** **Married** **Single**

(Circle One) **Divorced** **Separated**

Optional: By providing your email address, your consent to receive email notifications and information on behalf of SCFS. You may opt out of this email service at any time by contacting us or following the opt-out instructions included in each email you receive.

Please include all household members related by blood/marriage/ adoption **Total Family Members:**

Name	DOB	Relationship	Gender	Annual Income
			Total Annual Income:	

Contact Phone Number: _________________________

Alternative Number: ____________________________

Are you employed: Yes/No ?

Were you laid off: furloughed: hours reduced: other due to COVID?
When did this circumstance begin?

How were you effected by COVID-19

____
____
____
____

What services are you seeking due to the COVID-19 Pandemic?

____

____

____

Signature: ____

Date: ____

OFFICE USE ONLY

Eligible for Cares Act Funding- YES/NO

If Yes

Intake Complete- YES/NO

Appointment scheduled – YES/NO

Assigned Case Manager-

If No was customer referred to FESS- YES/No

NC Relief Grant- YES/NO

Was Customer Referred to other community agency? YES/NO

What agency :

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