

CLIENT

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Birth Date

Start-Up Date

Inactive Date

Name: _____

Phone: (H) _____

Street/Apt#: _____

Phone: (Cell) _____

City/St/Zip: _____

Text: Yes ___ No ___

Email: _____

Gender (Circle): M /F /Unknown

Referred By: _____ Congregation affiliation: _____

Mobility: Cane ___ Crutches ___ Walker ___ Primary Language: _____

Rider Impairment: (Hearing, Memory, Vision, Communication) Covid Immunization Status: Yes ___ No ___

Medical Conditions/Comments: _____

Services Needed: Med Trans ___ Companion Trans ___ Friendly Caller ___ Friendly Visitor ___ Handy Helper ___

Are you a Veteran? Yes ___ No ___

Living Arrangement: Alone ___ Spouse: _____ Family ___ Friend ___ Other ___

Reporting on Income Levels will not affect your ability to receive service.**Annual Income:**1 Person household: Less than \$29,900 ___ Less than \$49,850 ___ Less than \$63,000 ___ More than \$63,000 ___
Decline to Report ___2 Person household: Less than \$34,200 ___ Less than \$56,950 ___ Less than \$72,000 ___ More than \$72,000 ___
Decline to Report ___**Race/Ethnicity- please answer both sections**

Select One: Hispanic or Latino ___ Not Hispanic or Latino ___

Select one: Race/Ethnicity: White/ Caucasian: ___ Black/African American: ___ American Indian or Alaskan Native: ___

Asian: ___ Native Hawaiian & Other Pacific Islander: ___ Multiracial: ___ Other/Not Reported: ___

Other Data by Household:

Female Headed Household (single female is head of household): circle one: yes ___ no ___

Familial Status (households w children under age 18): circle one: yes ___ no ___

Disabled (you or another in the household having a physical or mental impairment that substantially limits one or more major life activities; hearing, visibility, mobility, chronic alcoholism, chronic mental illness, AIDS, mental disabilities): yes ___ no ___

Elderly in household (persons aged 55 or older): circle one: yes ___ no ___

One or more unemployed persons in household (seeking work >18 years old): circle one: yes ___ no ___

Participate in TANF (Temporary Assistance to Needy Families): circle one: yes ___ no ___

Emergency Contact: Name: _____ Relationship to Client: _____ Email: _____

Street: _____ City/St/Zip: _____ Phone: _____

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