St. Vincent de Paul Georgia

Date:_____

Conf: _____

Case Record Form

Case #:_____

Head of House: (First) (Middle) (Last) (Maiden) (Soc Sec #) -opt	**Date of Birth:**	**Gender:**	**Race*:**
Spouse/Other Adult: (First) (Middle) (Last) (Maiden) (Soc Sec #) -opt	**Date of Birth:**	**Gender:**	**Race*:**
Address: (Street) (Apt) (City) (State) (Zip)	**Home Phone#** **Work#** **Other#**		
County: **How long here?**	**Marital Status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Unmarried Couple ☐ Widowed ☐ Deserted		**Home Visit:** ☐Yes ☐No **Date:** **Mileage:** **Duration:**

Household Make-Up				**Other Information**	
Children	D.O.B.	Gender	Race*	Employer:	Fulltime: Parttime:
				How long employed:	
				Previous employer:	
				How long employed:	
Others:					
Total # People: (in household)				**Helped by SVDP Before:** ☐Yes ☐No When:	

***Race/Ethnicity Key**

A Asian
B/AA Black/African American
C White/Caucasian
H/L Hispanic/Latino/a
O Indicate other race/ethnicity

Church Affiliation:

Medicare ☐Yes ☐No	**Medicaid** ☐Yes ☐No	**Food Stamps** ☐Yes ☐No	**Veteran** ☐Yes ☐No	**WIC** ☐Yes ☐No

Income	**Monthly Amount**	**Expenses**	**Monthly Amount**	**Outstanding Bills**	**SVDP Help Given**
Alimony		Alimony			
Child Support		Child Support			
Employment		Child Care			
Spouse/Roommate Employment		Food			
Food Stamps		Electricity			
Retirement/Pension		Water/Sewer			
Social Security		Natural Gas/Propane/Heating Oil			
SSI, SSD		Telephone			
TANF (AFDC)		Rent/Mortgage			
Unemployment		Prescriptions/Medical			
Veteran Benefits		Transportation/Car Payments			
Workers' Compensation		Insurance (Auto, Health, Dental, Life)			
		Loans/Credit Card			
		Cable/Satellite			
Other:		Other:			
Total Income:		Total Expenses:			

Agencies applied to within the last 12 months (Please give info on all that apply):

Name of Agency	Purpose of Request	Amount Given	Date
_____	_____	_____	_____
_____	_____	_____	_____

Client Signature: _____ Date: _____ (Permission to log/release/verify info.)

Caseworker Name: _____ Time: _____ Mileage: _____

Please provide brief summary information, extenuating circumstances or supporting comments on why assistance is needed:

Notes from Follow up call:
Date:

Purpose of Request: Please give amount(s) needed on all that apply:

$_____ Affordable Housing
$_____ Dental or Medical Supplies
$_____ Emergency Housing/Lodging
$_____ Mortgage/Rent
$_____ Prescriptions
$_____ Telephone
$_____ Transportation
$_____ Utilities (Type_____)
$_____ Miscellaneous/Other
(Specify:_____)

How was this need taken care of in the past? (Mark all that apply)

☐ Alimony
☐ Child Support
☐ Employment
☐ Food Stamps
☐ HUD/Assisted Living
☐ Medicaid
☐ Retirement
☐ Social Security
☐ SSD/SSI
☐ TANF(AFDC)
☐ Unemployment
☐ Veteran's Benefits
☐ Other (specify:_____)

Check Request 1			**Check Request 2**		
Asst. Type _____ Check Amount: $_____ Customer Name _____ Vendor: _____ Mail To: _____ _____ _____			Asst. Type _____ Check Amount: $_____ Customer Name _____ Vendor: _____ Mail To: _____ _____ _____		
Check # Check Date	Check Mailed on:	OR Check Delivered to:	Check # Check Date	Check Mailed on:	OR Check Delivered to:

SVDP Assistance: (Check All that apply) Job Obtained ☐ Referral Given ☐ Travel Aid ☐ Spirit Aid/Sacrament ☐
Budget Counseling ☐ Referred to Consumer Credit Counseling ☐ (1-800-251-2227) Provided/Referred for Food ☐
Benefits Screening ☐Yes ☐No If "No" then why not?