

# Informational Form

Today's Date: \_\_\_/\_\_\_/\_\_\_



File Number

## Personal Information

Last/First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Gender: \_\_\_ Male \_\_\_ Female

Address: \_\_\_\_\_ Race: \_\_\_\_\_ Age: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Registered Voter? \_\_\_\_\_

White  
 Black/African American  
 Asian  
 American Indian or Alaska Native  
 Native Hawaiian or other Pacific Islander  
 Multi-Racial:  
      Black/African American/White  
      Asian/White  
      American Indian/Alaska Native/White  
      American Indian/Alaska Native/Black  
      Other: \_\_\_\_\_

Are you Hispanic?  
 Yes or  No  
 Nationality: \_\_\_\_\_

## Program/Support

- |   |   |  |
|---|---|--|
| <input type="radio"/> OMH Supported Housing         | <input type="radio"/> Family Services               | <input type="radio"/> Youth Leadership Program |
| <input type="radio"/> Mental Hygiene Programs       | <input type="radio"/> Housing and Tenant Counseling | <input type="radio"/> After School Program     |
| <input type="radio"/> Life Skills                   | <input type="radio"/> Computer Classes              | <input type="radio"/> Youth Summer Program     |
| <input type="radio"/> Vocational                    | <input type="radio"/> Citizenship/ESL Classes       | <input type="radio"/> DOL/DSS                  |
| <input type="radio"/> Drop-in Center                | <input type="radio"/> Food Pantry                   |  |
| <input type="radio"/> Medicaid Service Coordination |   |  |

## Educational Information (Student Only)

Grade: \_\_\_\_\_ Strongest subject: \_\_\_\_\_

School: \_\_\_\_\_ Weakest subject: \_\_\_\_\_

Are you diagnosed with a learning or mental disability  Yes or  No If yes, please speak to a counselor

Parent/Guardian Name: \_\_\_\_\_ Address: \_\_\_\_\_ Level of Education: \_\_\_\_\_

## Family Household Information

Insurance provider:

<input type="radio"/> Medicare <input type="radio"/> Medicaid <input type="radio"/> Affinity Health Plan <input type="radio"/> Fidelis Care <input type="radio"/> Health First <input type="radio"/> United Healthcare <input type="radio"/> Other <input type="radio"/> None	Female Head of Household Family? <input type="radio"/> Yes or <input type="radio"/> No Contact Information: Home Phone #: _____ Cell Phone #: _____ Family Size: Adults _____ Children _____	Source of Income: <input type="radio"/> Free/Reduced School Lunch <input type="radio"/> Public Assistance <input type="radio"/> Food Stamp <input type="radio"/> Social Security / SSD/SSI <input type="radio"/> Housing Subsidies <input type="radio"/> Employment <input type="radio"/> Unemployment <input type="radio"/> Child support
--	--	--

Please Circle indicating the income range your family falls into based upon family size.

Family Size	1	2	3	4	5	6	7	8
<b>a. This income</b>	\$22,900	\$26,200	\$29,450	\$32,700	\$35,350	\$37,950	\$40,550	\$43,200
<b>b. Between a. and this income</b>	\$38,150	\$43,600	\$49,050	\$54,500	\$58,900	\$63,250	\$67,600	\$71,950
<b>c. Between b. and this income</b>	\$55,800	\$63,750	\$71,700	\$79,650	\$86,050	\$92,400	\$98,800	\$105,150
<b>d. More than c.</b>	\$59,400+	\$67,900+	\$76,400+	\$84,900+	\$91,650+	\$98,450+	\$105,250+	\$112,050+

Brentwood Office: 10 Third Ave., Brentwood, NY 11717 (631) 434-3481  
 Central Islip Office: 83 Carleton Ave., Central Islip, NY 11722 (631) 234-1049