MANIILAQ ASSOCIATION ELDER 60 and OVER FOOD ASSISTANCE PROGRAM APPLICATION

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS ON THIS FORM. INCOMPLETE FORMS WILL NOT BE REVIEWED. THE DATA YOU PROVIDE IS CRITICAL TO DETERMINE ELIGIBILITY FOR FOOD ASSISTANCE. THE INFORMATION YOU PROVIDE IS PROTECTED BY PRIVACY AND SECURITY AGREEMENT. NAMES AND IDENTIFIERS WILL NOT BE SHARED.

Name: First ______________________________ *Initial* _________ *Last* ______________________________

*Date of Birth*_____________________________ *Date this form completed*_____________________________

Month Day Year *Month Day Year*

Address:

*Physical*____________________________________

Mailing (if different than physical address)

____

City ______________ *State* _________*ZIP*_________

Please Check ✓

Do you live alone *Yes*______ *No*______

Gender *Female*_____ *Male*______

NUMBER OF PEOPLE IN HOUSEHOLD _________

APPLICANTS MONTHLY INCOME $____________

ALL OTHER HOUSEHOLD INCOME $___________

TOTAL HOUSEHOLD INCOME $______________

EMERGENCY CONTACT

CONTACT NAME_____________________________

PHONE NUMBER_____________________________

Please check activities you need assistance with:

- ____*Eating*
- ____*Bathing*
- ____*Dressing*
- ____*Toileting*
- ____*Walking*
- ____*Transferring*
- ____*Cooking*
- ____*Shopping*
- ____*Medication*
- ____*Telephone*
- ____*Money Managing*
- ____*Housework*
- ____*Transportation*

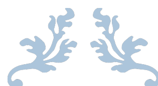
Ethnic Race

- ____*Alaskan Native/American Indian*
- ____*Asian*
- ____*Black/African American*
- ____*Native Hawaiian/Pacific Islander*
- ____*White*

Ethnicity

- ____*Hispanic/Latino*
- ____*Not Hispanic/Latino*

SUBMIT APPLICATIONS TO: scarlett.beaver@maniilaq.org or fax to: 907-442-4375



For Office Use

Date Received____________________________ Approved______ Amount______ Not Approved______