



Gerri Mason Family Support Center (GMFSC) Application and Intake Form



NOTE TO PARENT/GUARDIAN/HEAD OF HOUSEHOLD:

- Please complete **ALL** sections of this application, including the signature section on the back side. Incomplete and/or unsigned applications **CANNOT** be processed. **Please use Blue Ink Only.**
- Apply only for children age 17 years and younger who reside in Mineral County, including children who are not yet in school. If a child is school-aged, that child must be enrolled in school (Head-start/Pre-K to grade 12) to receive assistance. Children 18-21 may qualify if still enrolled in Mineral County Schools.
- Apply only for children who are in your legal and physical custody only.
- Must provide a physical address; we do **NOT** accept P.O. Box as primary address. If homeless, please specify.
- You must provide proof of earned/unearned income i.e., check stub or any assistance (TANF, Food Stamps, etc.) collected by applicant. **\$0 listed as income is not acceptable.**
- **All applicants MUST meet the income guidelines (at or below 300% of the Federal Poverty Level per DHHR).**
- **All applicants MUST be referred (self, school, childcare center, church, etc.).**
- **All completed applications are subject to further request of information by the GMFSC.**

HEAD OF HOUSEHOLD NAME _____ DOB: ____/____/____
First MI Last

PHYSICAL ADDRESS _____

CITY _____ STATE _____ ZIP _____

Please provide two phone numbers and an email. If your application is approved, you will be contacted by telephone. **If your contact information changes, it is your responsibility to update GMFSC at 304-790-6250.**

(1) PHONE # (_____) _____ - _____ Whose #? _____ Best Time? _____

(2) PHONE # (_____) _____ - _____ Whose #? _____ Best Time? _____

(3) EMAIL: _____ Whose Email? _____

HOUSEHOLD INFORMATION

TOTAL NUMBER OF PEOPLE LIVING IN YOUR HOME _____ ADULTS _____ CHILDREN

Please report monthly gross income for **ALL** members of your household, even if not a family member. (For example, if you live with your grandparents, include your grandparents' income.)

HOUSEHOLD EARNED INCOME FROM WORKING (before taxes) \$ _____ / month

HOUSEHOLD UNEARNED INCOME (SSI, UCI, Food stamps, etc.) \$ _____ / month

Family Housing:

- Rent
- Own
- Temporary (shelter, with relatives/friends, etc.)
- Share with relatives/friends
- Homeless

**Do any of the following circumstances apply?
(check all that apply):**

- I am a grandparent.
- I am a teen parent.
- I have been diagnosed with a cognitive or physical disability.
- I have limited English proficiency.
- None of the above

HEAD OF HOUSEHOLD INFORMATION

Gender:

- Female
- Gender non-conforming
- Self-describe: _____
- Male
- Non-binary

**PLEASE COMPLETE ALL SIDES OF THE APPLICATION.
INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.**

Relationship Status:

- Single
- Partnering
- Married
- Separated
- Divorced
- Widowed

Employment Status:

- Employed full-time
- Employed part-time
- Employed with seasonal or temporary work
- Not employed

Race/Ethnicity (Check all that apply):

- Native American/ Alaskan Native
- Native Hawaiian/ Pacific Islander
- Asian
- White
- Black or African American
- Multi-racial
- Middle Eastern
- Hispanic/ Latino (a/e/x)
- Other (please specify): _____
- Prefer not to say

Highest Level of Education:

- Elementary or junior high school/ middle school
- Some high school
- High school diploma or GED
- Trade or vocational school
- Some college
- 2-year college degree (Associate/Certificate)
- 4-year college degree (Bachelor's)
- Master's Degree or higher

CURRENT SERVICES

Check to indicate whether your family receives, needs assistance with, or does not need each service.

Service	Receives	Needs	Not Needed
TANF (a check from the state)	○	○	○
Supplemental Nutrition Association Program (SNAP)	○	○	○
Women and Infants (WIC)	○	○	○
Social Security Disability Income (SSDI) or Supplemental Security Income (SSI)	○	○	○
Children's Health Insurance Program (WV CHIP)	○	○	○
Earned Income Tax Credit (EITC)	○	○	○
Unemployment benefits	○	○	○
Assistance with heat, water, &/or electric	○	○	○
Medicaid	○	○	○

Service	Receives	Needs	Not Needed
Head Start/Early Head Start	○	○	○
Child Care (Child Care Subsidy like Mountain Heart, etc.)	○	○	○
Day Care – Family or a Center	○	○	○
Pre-K (4 year olds)	○	○	○
Parents as Teachers (prenatal to age 5)	○	○	○
Playgroup	○	○	○
Developmental Screening	○	○	○
Education/Training	○	○	○
Adult Literacy	○	○	○
Computer classes/training	○	○	○
Vocational/Educational training	○	○	○

Service	Receives	Needs	Not Needed
Household Budgeting	○	○	○
Family Planning	○	○	○
Mental Health Counseling	○	○	○
Disabilities	○	○	○
Health/ Nutrition	○	○	○
Breast Feeding	○	○	○
Right from the Start	○	○	○

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Service	Receives	Needs	Not Needed
Employment Opportunities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clothing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Relationships	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (please specify) _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CHILDREN CURRENTLY IN YOUR LEGAL/PHYSICAL CUSTODY (Age 0-17 years and in school if school-aged)

CHILD FIRST NAME	CHILD LAST NAME	M/F	DATE OF BIRTH	*YOUR RELATIONSHIP	SCHOOL	GRADE	*Disability
							Yes No
							Yes No
							Yes No
							Yes No
							Yes No
							Yes No
							Yes No
							Yes No

*Your Relationship (e.g. birth parent, step-parent, adoptive parent, legal guardian, foster parent, grandparent, great-grandparent, sibling, etc.)
 *Disability- Has your child ever been diagnosed with a cognitive or physical disability?

Reminder: The applicant must be referred. All information provided must be true, and the applicant understands the decision of acceptance is at the full discretion of the GMFSC.

Please Note: Due to a lack of funding or product, the GMFSC may not be able to provide assistance to all families that apply. If your application is approved, you will be contacted by telephone. Your patience is appreciated.

RELEASE OF CONFIDENTIAL APPLICANT AND RECIPIENT INFORMATION

I, _____, do hereby consent to the release of the
 (printed parent/guardian/head of household name)

following confidential information:

- Income and household composition and this completed application to the GMFSC

I authorize the release of this information to the following person(s) only:

- Mineral County Family Resource Network (Umbrella Agency)
- Gerri Mason Family Support Center

Furthermore, I authorize the use of this information for the following purpose only:

- Eligibility for GMFSC Assistance

I understand that I am waiving any applicable state and/or federal confidentiality rights that I may possess. I understand that additional information may be requested, i.e. proof of residency, custody, income, etc.

I understand that the misuse of this information by any person(s) may be punishable by state and/or federal law.

 APPLICANT SIGNATURE

 DATE

Are you interested in learning more about resources in your community? Yes _____ No _____