



# CLIENT SCREENING FORM

*This form is meant to help you and HHS staff determine eligibility for services. Please keep in mind that your particular eligibility may be more complicated than can be captured in this checklist. You will need to speak to an HHS staff person to complete the eligibility process.*

*If you have any questions about these eligibility requirements, you can call HHS at 582-7781 (St. Petersburg) or 464-8400 (Clearwater).*

**PLEASE ANSWER ALL QUESTIONS.  
BRING THIS FORM AND ALL NEEDED DOCUMENTATION WITH YOU TO HHS.**

**Name:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

Are You:

Yes	No	Programs	Documentation We Need	Ver
<input type="checkbox"/>	<input type="checkbox"/>	<b>FINANCIAL ASSISTANCE:</b> Disabled or unable to work because of a medical condition and <b>NOT</b> receiving Federal Disability benefits.	Written documentation from doctor that includes diagnosis and time unable to work. If married, a physician statement that spouse is also disabled or needed in household to provide care. <b>(Also, please provide copies of any medical records you have.)</b>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Single pregnant woman in 7-9th month	Written documentation or verification form from doctor, ARNP, PA, Nurse midwife which includes month of pregnancy.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<b>EMERGENCY ASSISTANCE:</b> Experiencing a Housing and/or Utility Emergency, have custody of minor children, <b>and</b> waiting for one of the items below: <ul style="list-style-type: none"> <li>• First Temporary Cash Assistance (TCA) check and not sanctioned.</li> <li>• First Unemployment check, or</li> <li>• First paycheck from new job</li> </ul>	Proof of past due utilities and/or eviction notice from landlord <b>and</b> proof of pending TCA from Dept. of Children and Families (DCF), pending unemployment from Dept. of Labor and Employment Security, or written verification from employer of first pay date and salary. <b>NOTE: You are NOT eligible for services if you have received benefits from this program within the past five (5) years.</b>	<input type="checkbox"/>

**STOP!** If you answered “No” to **all** of the above questions, you are not eligible for services.

Yes	No	Residency	Documentation We Need	Ver
<input type="checkbox"/>	<input type="checkbox"/>	Residing in Pinellas County and intend to stay.	<b>TWO (2)</b> of following with local address: drivers license, mortgage, lease, rent receipt, home ownership proof, homestead exemption, utilities, Vehicle Registration, Voter ID, School enrollment for children, statement from other social service agency with documented residency, Canceled mail from govt agency, declaration of domicile at clerk of court, food stamp referral, Library Card, Professional License, Criminal arrest record, Bank statement	<input type="checkbox"/>
Yes	No	Age	Documentation We Need	Ver
<input type="checkbox"/>	<input type="checkbox"/>	At least 18 years old and 64 years or less.		<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Under 18 and emancipated	Proof of emancipation: marriage certificate, court order, etc.	<input type="checkbox"/>
Yes	No	Citizenship	Documentation We Need	Ver
<input type="checkbox"/>	<input type="checkbox"/>	US Citizen by birth in US		<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	US Citizen by naturalization	Certificate of Naturalization	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Legal Permanent Resident	Current INS forms I-551 or I-151	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Refugee, Asylee, or Sponsored Alien within first 5 years of residency	Please ask.	<input type="checkbox"/>
Yes	No	Identification	Documentation We Need	Ver
<input type="checkbox"/>	<input type="checkbox"/>	Do you have two proofs of identification:	<b>TWO (2)</b> forms of ID, one must be Social Security Card or proof of application. The other can be a current driver's license, birth certificate, Food Stamp card, marriage license or voter's regis. card.	<input type="checkbox"/>

## Income Limits

Have you, your spouse, or partner (if you have children in common) received any of these sources of income within the past three months or plan to start receiving in the next month?

Yes	No	Earned Income	Documentation We Need	Ver
<input type="checkbox"/>	<input type="checkbox"/>	Wages or Salary from a Job	Written verification from employer of first pay date and salary.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Sick leave or vacation pay	Paystub or written verification from employer.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Self Employment or Contracted Employment	Contract, written statement from contractor, bank records, personal records, accountant's statement, tax records	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Day Labor	Written verification from employer of first pay date and salary.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Work for friends or relatives	Verification from anyone you worked for in the past 3 months.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Income from Providing Room and Board to Another	Lease, accountant's records, business records, receipts, tax statements, tenants' written statements.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Income from Rental of Room, Rental of Real Estate, Rental of Business Property	Lease, accountant's records, business records, receipts, tax statements, tenants' written statements.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Selling cans, blood, plasma, etc.	Written statement from purchaser.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Income tax refund	Date and amount of tax return, proof of expenses paid with refund.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other, please specify: _____	Written documentation of income source.	<input type="checkbox"/>
Yes	No	Unearned Income	Documentation We Need	Ver
<input type="checkbox"/>	<input type="checkbox"/>	Cash contributions from friends or relatives, including payment of your bills or rent.	Written statement from contributor.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Personal loans	Written statement from the loan-giver, including the amount, date of receipt, and purpose of the loan.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Bank or credit card loan, including credit card cash advances	Loan contract, written statement from lender, or credit card statement.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Insurance Settlement	Letter from insurance company, attorney's letter, receipts for replacement of asset or medical care.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Workers Compensation	Letter from insurance company, attorney's letter, receipts for medical care.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Legal Settlement	Legal documents, written statement from attorney, documentation of items intended to pay from settlement.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Child Support	Court records, DCF records, divorce papers, written statement from person paying support.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Temporary Cash Assistance	DCF referral or other written statement from DCF.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Social Security / SSI	Benefit award letter, written statement from SSA, verification from another agency that has obtained documentation.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Student Loans or Grants / Scholarships	Award letter, loan contract, written statement from school administrator. Also proof of tuition and educational expenses.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Interest / Dividends	Bank statement, letter from financial institution.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Income from Another Agency, i.e. Home Care for the Elderly, Utility Allowance, etc.	Approval letter, written statement from agency representative.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Compensation	Written statement from Dept. of Labor & Employment Security.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Veterans Benefits	Written statement from VA.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Pensions	Written statement from organization providing benefit.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other, please specify: _____	Written documentation of income source.	<input type="checkbox"/>

**STOP!** The Income Limit is \$450/mo for 1 person (Add \$50 for every eligible household member). If your income exceeds the limit, you are not eligible for services.

**Asset Limits**

Do you, your spouse, or partner (if you have children in common) have any of these assets?

Yes	No	Asset	Documentation We Need	Ver
<input type="checkbox"/>	<input type="checkbox"/>	Bank Accounts	Most recent bank statement, letter from financial institution.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Business Accounts, Equipment	Bank statement for business accounts, tax assessor records, lists of equipment, makes, models, value.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cash		<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Collectables	Written statement of value from dealer, club or business.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other Financial Investments like 401K, stocks, bonds, etc.	Statement from financial institution or investment company. Value from financial institution, newspaper, bank, etc.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Real Estate (not homestead)	Deeds, liens, county records.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other, please specify: _____	Written documentation of asset.	<input type="checkbox"/>

**STOP!** The Asset Limit is \$500 for 1 person (Add \$50 for every eligible household member). If your assets exceed the limit, you are not eligible for services.

**Pending Benefits/Resources**

Are you, your spouse, or partner (if you have children in common) applying for any of the following?

Yes	No	Pending Benefits/Resources	Documentation We Need	Ver
<input type="checkbox"/>	<input type="checkbox"/>	Pending Car Accident Litigation or other Lawsuit	Legal documents, written statement from attorney, & police report.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	SSI/SSDI	Written statement from SSA.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Veteran's Compensation	Written statement from the VA.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Food Stamps	Referral from DCF.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Workers Comp	Letter from insurance company, attorney's letter.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment	Written statement from Department of Labor and Employment Security.	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other, please specify: _____	Written documentation of asset.	<input type="checkbox"/>

**BY MY SIGNATURE I AM STATING THIS INFORMATION IS TRUE AND COMPLETE.**

\_\_\_\_\_  
(Client's Signature)

\_\_\_\_\_  
(Date)

**If it appears that you are not eligible for services, call 2-1-1 or 210-4211 (from a cell phone) for referrals to organizations that can assist you or pick up an organization referral list from any HHS office.**



# CLIENT APPLICATION FORM

**PLEASE PRINT AND RETURN TO THE FRONT DESK ONCE COMPLETED.**

*The Pinellas County Department of Health and Human Services collects your Social Security number in order to process billing and payments on your behalf as a client of the Department. Your Social Security number is also used as a unique numeric identifier and may be used for search purposes. This notice is provided pursuant to Section 119.071(5) Florida Statutes (2007).*

**Today's Date:** \_\_\_\_\_

HH #	Your Name (Last, First, MI)	Social Security #	DOB	Race	Gender
1					<input type="checkbox"/> M <input type="checkbox"/> F

**List your current and previous address. Also provide your mailing address if different.**

Address	Apt. #	City	State	Zip	From		To	
					Mo	Yr	Mo	Yr
Previous:								
Current:								
Mailing:								

**Who lives with you in your current residence? (Must provide I.D. for all members of the Assistance Group.)**

HH #	Legal Name (Last, First, MI)	AG (✓)	Social Security #	DOB	Relationship	Gender
2						

**Date You Moved to Pinellas County:** \_\_\_\_\_

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

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

**To be completed by Eligibility Specialist**  
 Verification of Residency: \_\_\_\_\_  
 \_\_\_\_\_

**List Two Emergency Contacts:**

Name	Address	Phone #	Relationship
1) _____	_____	_____	_____

2) \_\_\_\_\_

1. Were you born in the USA?  Yes  No

If No, what country were you born in: \_\_\_\_\_ (Must provide birth certificate if a U.S. citizen, born outside the continental U.S.)

2. Are you a U.S. Citizen?  Yes  No

If No, what is your immigration status: \_\_\_\_\_ (Must provide proof of immigration status or naturalization.)

3. What is your current marital status?

Never Married  Married  Divorced  Widow(er)  Separated (month/year):

**If divorced**, please list the names of all former spouses, the date of divorce, and married over 10 years:

Name	Month/Year	Married over 10 years?
1) _____	_____/_____/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) _____	_____/_____/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) _____	_____/_____/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Do you have any minor children?  Yes  No

**If children are not in your custody**, list the names & DOB of the children and who has custody of them:

Child's Name	DOB	Name & Relationship of Person who has Custody
1) _____	_____/_____/_____	_____
2) _____	_____/_____/_____	_____
3) _____	_____/_____/_____	_____

5. Have you ever served in the military?  Yes  No

If yes, Dates Served, Branch, & Type of Discharge: \_\_\_\_\_  
Dates Served Branch Type of Discharge

6. **If married**, has your spouse ever served in the military?  Yes  No

If yes, Dates Served, Branch, & Type of Discharge: \_\_\_\_\_  
Dates Served Branch Type of Discharge

**To be completed by Eligibility Specialist**

Verification of Veteran Status: \_\_\_\_\_

Is the applicant eligible for or receiving VA Medical benefits? \_\_\_\_\_

Is the applicant eligible for or receiving a VA pension? \_\_\_\_\_

If discharged under conditions other than honorable, can the Veteran's discharge status be upgraded? \_\_\_\_\_

BY MY SIGNATURE I AM STATING THIS INFORMATION IS TRUE AND COMPLETE.

\_\_\_\_\_  
(Client's Signature)

\_\_\_\_\_  
(Date)



<b>Date:</b>
<b>SSN /CMR#</b>

## HEALTH & VOCATIONAL HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential  
and will become part of your medical record.

<b>Name</b> <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>
Are you currently being treated by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has your condition lasted or can it be expected to last at least twelve months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has your condition caused you to stop working or substantially reduce your work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>PERSONAL HEALTH HISTORY</b>			
Present Illness: (Describe briefly your present complaint)			
List any medical problems other doctors have diagnosed			
<b>List your prescribed drugs and over-the-counter drugs (if necessary, attach a separate sheet of paper)</b>			
Drug Name / Strength (Dosage) / Frequency Taken		Drug Name / Strength (Dosage) / Frequency Taken	
<b>Hospitalizations including Mental Health</b>			
Year	Reason	Hospital	
<b>Diagnostic testing within the last 12 months</b>			
Month/Year	Name of test and reason ordered	Facility	

Check if you have, or have had any of the following problems/diseases?		
<input type="checkbox"/> Asthma/COPD	<input type="checkbox"/> Musculoskeletal Disorders	<input type="checkbox"/> Diabetes (high blood sugar or diabetic related problems)
<input type="checkbox"/> Hypertension (high blood pressure)	<input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/> Autoimmune Disease (Arthritis, Lupus, Fibromyalgia, Crohn's Disease)
<input type="checkbox"/> Migraine	<input type="checkbox"/> Infectious Disease (Hep-C-HIV-MRSA)	<input type="checkbox"/> Gastrointestinal
<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other:
<input type="checkbox"/> Kidney Disease (dialysis, renal issues, stones)		

Psychiatric History		
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Organic Brain Disorder	<input type="checkbox"/> Post Traumatic Stress Disorder (PTSD)
<input type="checkbox"/> Schizophrenia/Schizo-Affective	<input type="checkbox"/> Affective Disorder	<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Mentally Challenged	<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Personality Disorder	<input type="checkbox"/> Major Depression	<input type="checkbox"/> Other:

Limitations (Check any of the following items that your illnesses, injuries, or conditions affects)		
<input type="checkbox"/> Lifting	<input type="checkbox"/> Sitting	<input type="checkbox"/> Concentration
<input type="checkbox"/> Kneeling	<input type="checkbox"/> Reaching	<input type="checkbox"/> Following Instructions
<input type="checkbox"/> Bending	<input type="checkbox"/> Using Hands	<input type="checkbox"/> Memory
<input type="checkbox"/> Squatting	<input type="checkbox"/> Seeing	<input type="checkbox"/> Understanding
<input type="checkbox"/> Standing	<input type="checkbox"/> Talking	<input type="checkbox"/> Completing Task
<input type="checkbox"/> Walking	<input type="checkbox"/> Hearing	<input type="checkbox"/> Other:
<input type="checkbox"/> Stair Climbing	<input type="checkbox"/> Getting Along with Others	

Do you use any of the following? Which are prescribed by a doctor?	
<input type="checkbox"/> Crutches	<input type="checkbox"/> Cane
<input type="checkbox"/> Walker	<input type="checkbox"/> Brace/Splint
<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Other:

EDUCATION AND TRAINING		
<b>Circle highest grade completed:</b>		
4 5 6 7 8	9 10 11 12	13 14 15 16
Grade School	High School	College
Degree(s) awarded, if applicable:		

**Vocational, Trade, Armed Forces, Business Schools and Training:**

Kind of Training	Conducted by	Date Completed
<b>Previous Work or Specialty</b>		
<b>Do you possess a current, valid driver's license: <input type="checkbox"/> Yes <input type="checkbox"/> No</b>		
<b>If no, state reason:</b>		