



*Olde Towne*  
Medical & Dental Center

Date \_\_\_\_\_ Staff/Volunteer \_\_\_\_\_

### Household Information

Head of Household: \_\_\_\_\_

Last Name First Name MI

DOB \_\_\_\_\_ Age \_\_\_\_\_ SSN (optional) \_\_\_\_\_

Primary Race \_\_\_\_\_ Secondary Race \_\_\_\_\_ Hispanic (Y/N)?

Gender \_\_\_\_\_ Marital Status \_\_\_\_\_ Telephone Number \_\_\_\_\_ (Circle Cell or

Landline) Text? \_\_\_\_\_ Secondary Phone Number \_\_\_\_\_ Email \_\_\_\_\_

Additional Household Members: Total Adults: \_\_\_\_\_ Total Children: \_\_\_\_\_

Last, First MI	Relationship	DOB	Age	Race	Hispanic?	Gender?

Street Address: \_\_\_\_\_

(Circle One) JCC Williamsburg City York Other \_\_\_\_\_



### Financial Information

**Wages:**

**Head of Household:**

Employer: \_\_\_\_\_ FT PT Seasonal \$ \_\_\_\_\_/hr./week/month \_\_\_\_\_ Hours per week

**Other Household Member**

Employer: \_\_\_\_\_ FT PT Seasonal \$ \_\_\_\_\_/hr./week/month \_\_\_\_\_ Hours per week

**Other Household Member**

Employer: \_\_\_\_\_ FT PT Seasonal \$ \_\_\_\_\_/hr./week/month \_\_\_\_\_ Hours per week

<b>Unearned Income and Benefits: (enter monthly amounts)</b>	Head of Household	Other Household Member	Other Household Member
Social Security Benefits (All types)			
Veteran's Disability			
Other Disability/Worker's Comp			
TANF/WIC			
Pension/Retirement			
Child Support			
Alimony/Spousal Support			
SNAP Benefits			
Other (Please list)			

**TOTAL HOUSEHOLD MONTHLY INCOME: \_\_\_\_\_**

\*Must provide proof of income (pay stubs, award letters, bank statements)