



Int. 1:	Int. 2:	Client No. _____
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LAMP 101-0207 – Application			Date: _____
First Name:	Middle Name:	Last Name:	
Social Security #	Picture Id #	<input type="checkbox"/> Driver's License <input type="checkbox"/> State ID	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Age:	Have you ever been to LAMP before: <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please circle service(s): Food/Clothing, Utilities, Healthcare, Shelter			

Race
<input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Black/African-American & White <input type="checkbox"/> American Indian or Alaskan <input type="checkbox"/> American Indian/Alaskan & Black <input type="checkbox"/> American Indian/Alaskan & White <input type="checkbox"/> Asian <input type="checkbox"/> Asian & White <input type="checkbox"/> Pacific Islanders

Ethnicity
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Non-Latino

Marital Status:
<input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed

Veteran
<input type="checkbox"/> Yes <input type="checkbox"/> No

Can You Walk?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> With Assistance <small>(Crutch, Walker, Wheelchair, Prosthesis)</small>

Homeless
<input type="checkbox"/> Yes <input type="checkbox"/> No

Client Contact Information:	Residence Type:
Street Address:	<input type="checkbox"/> Apartment or House you're Buying or Own
City:	<input type="checkbox"/> Emergency Shelter _____
State: Zip Code:	<input type="checkbox"/> Foster Care Home
County:	<input type="checkbox"/> Hospital
Home Phone:	<input type="checkbox"/> Hotel or Motel
Cell Phone:	<input type="checkbox"/> Other _____
Pager:	<input type="checkbox"/> Perm. Housing for Formerly Homeless
Work:	<input type="checkbox"/> Room, Apt. or House that you Rent
Other:	<input type="checkbox"/> Staying or Living with Family
Fax:	<input type="checkbox"/> Staying or Living with Friends
Email Address:	<input type="checkbox"/> Substance Abuse or Detox. Facility
	<input type="checkbox"/> Transitional Housing for Homeless

Service(s) Requested:
<input type="checkbox"/> Food
<input type="checkbox"/> Clothing
<input type="checkbox"/> Electric
<input type="checkbox"/> Water
<input type="checkbox"/> Natural Gas
<input type="checkbox"/> Rent
<input type="checkbox"/> Shelter
<input type="checkbox"/> Prescription
<input type="checkbox"/> Dental Extractions
<input type="checkbox"/> Eye Care
<input type="checkbox"/> Other _____

Emergency Contact (Not Living in the Household):			
Name:	Relationship:		
Street Address:			
City:	State:	Zip Code:	Phone:

Household (Other Persons Living In the Household):			
Name:	SS#	D.O.B.	Gender: M or F
Race:	Ethnicity:	Marital Status:	Relationship:

Name:	SS#	D.O.B.	Gender: M or F
Race:	Ethnicity:	Marital Status:	Relationship:

Name:	SS#	D.O.B.	Gender: M or F
Race:	Ethnicity:	Marital Status:	Relationship:

Name:	SS#	D.O.B.	Gender: M or F
Race:	Ethnicity:	Marital Status:	Relationship:

Income Sources for the Household (Monthly):			
Type	Client	Spouse - Other	
<input type="checkbox"/>	Child Support	\$	\$
<input type="checkbox"/>	Employment Income	\$	\$
<input type="checkbox"/>	Food Stamps	\$	\$
<input type="checkbox"/>	General Public Assistance	\$	\$
<input type="checkbox"/>	Labor Pool	\$	\$
<input type="checkbox"/>	Medicaid	\$	\$
<input type="checkbox"/>	Medicare	\$	\$
<input type="checkbox"/>	Pension	\$	\$
<input type="checkbox"/>	Social Security	\$	\$
<input type="checkbox"/>	Disability (SSDI)	\$	\$
<input type="checkbox"/>	Supplemental Income (SSI)	\$	\$
<input type="checkbox"/>	TANF	\$	\$
<input type="checkbox"/>	Veterans Benefits	\$	\$
<input type="checkbox"/>	WIC	\$	\$
<input type="checkbox"/>	Worker's Compensation	\$	\$
<input type="checkbox"/>	Other	\$	\$
<input type="checkbox"/>	None		
Total		\$	\$

Expense Items:		
Type	Monthly	
<input type="checkbox"/>	Cable	\$
<input type="checkbox"/>	Car Payment	\$
<input type="checkbox"/>	Child Care	\$
<input type="checkbox"/>	Child Support	\$
<input type="checkbox"/>	Clothing	\$
<input type="checkbox"/>	Credit Cards	\$
<input type="checkbox"/>	Electricity	\$
<input type="checkbox"/>	Entertainment	\$
<input type="checkbox"/>	Food	\$
<input type="checkbox"/>	Furniture	\$
<input type="checkbox"/>	Natural Gas	\$
<input type="checkbox"/>	Insurance	\$
<input type="checkbox"/>	Loan 1	\$
<input type="checkbox"/>	Loan 2	\$
<input type="checkbox"/>	Loan 3	\$
<input type="checkbox"/>	Medical	\$
<input type="checkbox"/>	Mortgage	\$
<input type="checkbox"/>	Rent	\$
<input type="checkbox"/>	Savings	\$
<input type="checkbox"/>	Telephone	\$
<input type="checkbox"/>	Transit	\$
<input type="checkbox"/>	Transportation	\$
<input type="checkbox"/>	Water	\$
<input type="checkbox"/>	Other	\$
Total		\$

Addictions:	
<input type="checkbox"/>	Alcohol Beer, Liquor, Moonshine, Wine
<input type="checkbox"/>	Cannabis THC, Hash, Pot
<input type="checkbox"/>	Depressants Quaaludes, Xanax, Barbituates
<input type="checkbox"/>	Hallucinogens LSD, PCP, MDA, Ecstasy, Mushrooms, Mescaline
<input type="checkbox"/>	Narcotics Demerol, Dlaudid, Codeine, Heroin, Opium
<input type="checkbox"/>	Stimulants Amphetamines, Caffeine, Cocaine, Crack, Crank, Speed
<input type="checkbox"/>	Other Freon, Butane, Gas, Glue, Paint, Poppers, Cigarettes
<input type="checkbox"/>	None

Insurance (health, dental, vision):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medicaid:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug Discount Cards:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medicare Rx Card:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Client Employment History (List most recent first):					
Employer:	Title:		Contact:		
Phone:	Start Date:	End Date:	Hours Per Week:		
Start Pay: \$	<input type="checkbox"/> hr <input type="checkbox"/> wk <input type="checkbox"/> mo	Ending Pay: \$	<input type="checkbox"/> hr <input type="checkbox"/> wk <input type="checkbox"/> mo		

Employer:	Title:		Contact:		
Phone:	Start Date:	End Date:	Hours Per Week:		
Start Pay: \$	<input type="checkbox"/> hr <input type="checkbox"/> wk <input type="checkbox"/> mo	Ending Pay: \$	<input type="checkbox"/> hr <input type="checkbox"/> wk <input type="checkbox"/> mo		

Employer:	Title:		Contact:		
Phone:	Start Date:	End Date:	Hours Per Week:		
Start Pay: \$	<input type="checkbox"/> hr <input type="checkbox"/> wk <input type="checkbox"/> mo	Ending Pay: \$	<input type="checkbox"/> hr <input type="checkbox"/> wk <input type="checkbox"/> mo		

Spouse Employment:					
Employer:	Title:		Contact:		
Phone:	Start Date:	End Date:	Hours Per Week:		
Start Pay: \$	<input type="checkbox"/> hr <input type="checkbox"/> wk <input type="checkbox"/> mo	Ending Pay: \$	<input type="checkbox"/> hr <input type="checkbox"/> wk <input type="checkbox"/> mo		



P.O. Box 3502 • Valdosta, Georgia 31601-3502 • (229) 245-7157

Eligibility Agreement:

I understand that each individual program is governed by its own rules and regulations. This means that while I may be eligible for one service, I may not be eligible for another. Furthermore, each program will have Individual Assistance Maximums. This means that I will only be eligible for services if I have not met my Individual Assistance Maximum.

Initial: _____

Release from Liability:

I understand that I am an at-will participant of any and all Lowndes Associated Ministries to People, Inc. programs. In consideration of the permission extended to me by Lowndes Associated Ministries to People, Inc., through its representatives, to participate in the program(s), I do, for myself, my heirs, executors, and others release and forever discharge, and agree to hold harmless Lowndes Associated Ministries to People, Inc. and all its officers, agents, servants, and employees, acting within the scope of their employment, from any and all claims, demands, actions, or causes of action which may arise in my favor, the property damage and/or personal injury or death resulting from said program(s) or continuances, resulting from any negligence or otherwise on the part of Lowndes Associated Ministries to People, Inc., or its officers, agents, servants, and employees, in connection with the above program, or programs. Furthermore, the recipients of any food from LAMP will hold them harmless from any and all liabilities, claims, or any obligations whatsoever arising out of or attributed to, any action in connection with their use of items supplied by this ministry.

Initial: _____

Medicaid Status Verification (Healthcare Program Only):

I understand that I have submitted an eligibility application for the Indigent Care Trust Fund Healthcare Program. I also understand that one condition of eligibility is that I may not be receiving Medicaid assistance. By signing below, I am certifying that I do not receive Medicaid assistance. Furthermore, I assert that I do not have access to any other traditional insurance assistance relative to my need.

Initial: _____

To the best of my knowledge, the information I included on my application is correct. Furthermore, I understand that LAMP, Inc. works with other local agencies including, but not limited to: DFCS, EOA, Red Cross, Salvation Army, and Social Security. LAMP, Inc. has my consent to share this information with other agencies. I also certify acknowledgement of the above paragraphs by signing below.

Signature: _____

Date: _____



Pathways Community Network Client Authorization Form

I understand that **Lowndes Associated Ministries to People, Inc.** (this agency) is part of the Pathways Community Network, a computer network designed to reduce the amount of time and effort it takes for me to obtain the social services I need. This agency has my permission to:

- Look at information about me in the Pathways system
- Enter in the system information concerning my situation and need for assistance

I understand that:

- Agencies in the Pathways system will keep this information confidential
- Other agencies will be able to look at this information only if I give each of these agencies my permission
- Staff at each agency receives regular training on client confidentiality and their legal responsibility to keep my information private
- The Pathways system uses passwords and computerized codes to protect my privacy
- Shared information may include my name, age, gender, marital status, veteran status, address, housing status, and basic information about my goals and the services I receive
- I can obtain a copy of information about me collected by the Pathways system, except for psychotherapy notes and other information kept private by law.

I also understand that I have the right to refuse to grant this authorization, and that even if I give permission for this agency to access my information in the Pathways system, I can revoke that permission at any time, without penalty. The permission I am giving this agency to view my information and to place information about me in the Pathways system will expire on: _____.

I also understand that under certain circumstances, this agency or Pathways may be legally required to disclose some or all of my confidential information. This may happen if there is any evidence of child abuse, if there is evidence I may harm others or myself, or if a court orders that my information be disclosed.

In order to improve services for persons in need, experts may study data from the Pathways system and other sources. As a result, an independent researcher may need to view personal information, such as names and Social Security numbers, to make sure that records are not counted twice. This researcher will remove all personally identifiable information before anyone else examines the data, so that the privacy of those who received services is protected. This procedure is done in accordance with professional standards, under strict government and research institution supervision, and in compliance with all regulations that specifically address those who have received services for mental health, substance abuse, HIV/AIDS, and domestic violence.

I authorize this agency to view my information, and to place information about me in the Pathways system.

Signature: _____ Date: _____

Print Name: _____ ID: _____ Date of Birth: _____

Witness Signature: _____

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