

**NORTHEAST NEBRASKA COMMUNITY ACTION  
PARTNERSHIP, INC. (NENCAP)  
BASIC INTAKE FORM**

**NENCAP does not discriminate on the basis of sex, age, religion,  
race, marital, or veteran status, handicap or national origin.**

Referred to NENCAP by \_\_\_\_\_

**INFORMATION ON THIS PAGE IS FOR THE PERSON SIGNING THIS  
FORM**

FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_

LAST NAME \_\_\_\_\_

BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_

**GENDER: (Circle one)** Male Female

**ETHNICITY : (Circle One)** Hispanic Non-Hispanic

**RACE: (Circle one or two/Specify if other)**

American Indian Black White Asian

Pacific Islander Other: \_\_\_\_\_

**MARITAL STATUS: (Circle one)**

Single Married Separated Divorced

Widowed Living together

**HIGHEST LEVEL OF EDUCATION ATTAINED: (Circle one)**

None Nursery-4th Grade K-8th Grade

9<sup>th</sup> Grade 10<sup>th</sup> Grade 11<sup>th</sup> Grade

12<sup>th</sup> Grade (No diploma) High School Diploma GED

Some College College Degree Tech School Grad

**HEALTH INSURANCE STATUS: (Circle one/Specify other)**

Medicaid/Adult Kids Connection Medicare

Private No Coverage(self pay) VA Benefits

Native American Insurance Other: \_\_\_\_\_

**HUD REQUIRED:(Circle all that apply)**

Are you a US Veteran: Yes No

Are you disabled: Yes No

If Yes: Physical Mental Blind Deaf  
Speech Developmental Behavioral

Is your disability long term: Yes No

Do you receive Food Stamps: Yes No

**EMPLOYMENT STATUS:**

Are You Currently Employed: Yes No

If Yes, Employment Status: Full Time Part Time

Hours per week \_\_\_\_\_ Hourly wage \_\_\_\_\_

**MONTHLY FAMILY INCOME (list all income for each member of  
the household, including; Wages, Child Support, TANF,  
Unemployment, Workmen's Comp, SSI, SSA, Alimony and any  
other income)**

\$ \_\_\_\_\_ Source \_\_\_\_\_ Recipient \_\_\_\_\_

\$ \_\_\_\_\_ Source \_\_\_\_\_ Recipient \_\_\_\_\_

\$ \_\_\_\_\_ Source \_\_\_\_\_ Recipient \_\_\_\_\_

\$ \_\_\_\_\_ Source \_\_\_\_\_ Recipient \_\_\_\_\_

\$ \_\_\_\_\_ Source \_\_\_\_\_ Recipient \_\_\_\_\_

Are you eligible for court ordered Child Support: Yes No

If yes, do you receive it: Yes No

**LIVING SITUATION: (Circle one/Specify other)**

Rent Own Provided Living with Family

Living with Friends Homeless Other \_\_\_\_\_

Do you receive a housing subsidy: Yes No

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

County of Residence \_\_\_\_\_

Phone # \_\_\_\_\_

Mailing Address (if different from street)  
\_\_\_\_\_

Length of time at current address \_\_\_\_\_

Previous Zip code \_\_\_\_\_

Monthly Housing Cost \_\_\_\_\_

Monthly Utility Cost \_\_\_\_\_

Means of transportation (Circle one)

Own car Public Walk Other people

**HOUSEHOLD TYPE: (Circle one/Specify if other)**

2 Parent Family Single Parent Female

Single Parent Male Parent + Significant Other

2+Adults no dependents Foster Parents

Single Person no children at home

Other: \_\_\_\_\_

Number Living in the Household \_\_\_\_\_

Are you pregnant: Yes No

If yes, projected due Date \_\_\_\_\_

**I hereby certify that to the best of my knowledge the  
information contained herein is true, correct and  
complete. I understand that my signature authorizes  
the following:**

1. To determine eligibility for services;
2. For release of information to services for which I may be eligible;
3. I authorize, NENCAP, as a Nebraska Management Information System (NMIS) user agency and its contracted agents, to disclose my basic identifying information to NMIS and to all of the NMIS user agencies. The disclosure will be made by entering the information into the NMIS database. Once the disclosure has been made in reliance upon this authorization, the information cannot be retrieved, and all current and future NMIS user agencies will be able to access, use, and disclose the information. The NMIS user agencies are health and human service providers who are permitted by the NMIS to access and enter data into the NMIS database, which allows them to collect, share, and use basic identifying information about service recipients.

I understand that the Agency cannot condition decisions about my treatment, payment, enrollment or eligibility for benefits or services on whether or not I sign this authorization. A copy of this authorization shall be as valid as the original. I understand that the information disclosed is subject to re-disclosure by the recipient and may no longer be protected by the federal privacy regulations, 45 CFR § 164 Subpart E.

I understand that I do not have to participate in the NMIS. I understand that I may revoke this authorization at any time, by doing so in writing to the NMIS user agency named above. A revocation of this authorization will be effective except to the extent the entity disclosing the information has taken action relying on this authorization. This authorization will expire one year from the date I sign it. I understand that revocation or expiration of this authorization will not affect information that has already been entered into the NMIS database in reliance on this authorization.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Agency Staff Signature \_\_\_\_\_

Date \_\_\_\_\_

**STAFF USE ONLY:**

Program: \_\_\_\_\_

Service start date: \_\_\_\_\_ End date: \_\_\_\_\_

**Household Member Basic Intake**

FIRST NAME: \_\_\_\_\_  
MIDDLE INITIAL: \_\_\_\_\_  
LAST NAME: \_\_\_\_\_  
BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
GENDER: Male \_\_\_\_\_ Female \_\_\_\_\_

**RELATIONSHIP TO THE APPLICANT**

Boy-Girlfriend      Son  
Parent                Daughter  
Cousin                Foster-Child  
Sibling                Spouse  
Grandchild           Grandparent  
Step-child            Step-parent  
Nephew/Niece        Uncle  
No Relation           Aunt

**ETHNICITY: (Circle one)**

Hispanic      Non-Hispanic

**RACE: (Circle one or two/Specify if other)**

American Indian    Black    White    Asian  
Other: \_\_\_\_\_

**MARITAL STATUS: (Circle one)**

Single/Never Married    Married  
Divorced                Separated  
Living together         Widowed

**HIGHEST LEVEL OF EDUCATION:**

None    Nursery-4<sup>th</sup> Grade    K-8th Grade  
9<sup>th</sup> Grade    10<sup>th</sup> Grade    11<sup>th</sup> Grade  
12<sup>th</sup> Grade    High School Diploma  
GED    Some College    College Degree  
Tech School Certification

**HEALTH INSURANCE STATUS:**

Medicaid/Adult      Kids Connection  
Medicare              No coverage (self pay)  
Private                 VA Benefits  
Native American Insurance  
Other (Please specify) \_\_\_\_\_

**HUD REQUIRED:**

US Veteran: Yes    No  
Disabled: Yes    No  
If yes: Physical    Mental    Blind    Speech  
                          Developmental    Deaf    Behavioral  
Long Term: Yes    No

**EMPLOYMENT STATUS:**

Are You Currently Employed?    Yes    No  
**If yes:** Full Time    Part Time  
Hours per week \_\_\_\_ Hourly wage \_\_\_\_\_  
**If no state reason:**  
\_\_\_\_\_

**STAFF USE ONLY:**

Program: \_\_\_\_\_  
Service Start Date: \_\_\_\_\_  
Service End Date: \_\_\_\_\_

**Household Member Basic Intake**

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