Client Name: ___________________________

Food Pantry Service

Application and Instructions

To aid and enhance the lives of those affected by Sickle Cell

MARTIN CENTER
SICKLE CELL INITIATIVE

Food Pantry Service

Martin Center Sickle Cell Initiative is a 501(c) (3) human services agency dedicated to aiding and enhancing the lives of those impacted by Sickle Cell Disease and Sickle Cell Trait in Central Indiana. Our programs include support and education for Sickle Cell and associated disorders. Through education, outreach, school partnerships, medical provider collaborations and advocacy, we endeavor to provide holistic services for those affected by Sickle Cell. Martin Center Sickle Cell Initiative assists the entire Sickle Cell community by providing solutions that address today's needs and reduce tomorrow's barriers for individuals and their families including providing supplemental food and hydrating beverages for individuals with Sickle Cell or other related blood disorders.

Eligibility

Candidates for the Martin Center Sickle Cell Initiative Food Pantry Service **twice monthly or enroll in the Gatorade Program must**:

- Be an adult with **Sickle Cell Disease** or a parent/guardian of a child with Sickle Cell Disease
- Maintain a permanent resident of Marion, Hamilton, Hancock, Morgan, Hendricks, or Boone Counties in Indiana.

Candidates for the Martin Center Sickle Cell Initiative Food Pantry Service **once monthly** must:

- Be an adult with **Sickle Cell Trait** or a parent/guardian of a child with Sickle Cell Trait
- Maintain a permanent resident of Marion, Hamilton, Hancock, Morgan, Hendricks, or Boone Counties in Indiana

Application Procedure

Eligible applicants must complete and submit the enclosed application.

All clients must have their Sickle Cell status verified prior to using the pantry.

Clients must fill out the Information and Pantry forms **prior to using the pantry**.

All new clients must be introduced to the Social Worker.

Clients who have previously had a proxy on file must fill out the forms for the New Year prior to their proxy being able to pick up pantry for them.

The client/or guardian is responsible for submitting the application to Mo Buell, MSW, LSW in person at Martin Center Sickle Cell Initiative, by email to: cowens@TheMartinCenter.org or by fax at 317-927-5167.

Participation Criteria

Applicants are advised that availability of certain pantry items may vary at times.

Forms are reviewed prior to the client leaving for missing information.

SCD clients may access the pantry twice per month with at least two full weeks' in-between visits to use the Pantry and Gatorade services.

Trait clients may access the pantry once per month for the Pantry service. Trait clients do not receive Gatorade.

Applicants are also advised that priority consideration will be given to applicants diagnosed with Sickle Cell Disease and/or applicants who are the parents or guardians of children with Sickle Cell Disease.

Martin Center Sickle Cell Initiative will reserve the right to conduct interviews with applicants if it feels it is necessary to do so in order to make its final decision.

MARTIN CENTER
SICKLE CELL INITIATIVE

Food Pantry Service Application

Instructions: ***Application must include:***
Client's full name and address
Personal information
Client's signature

DISEASE ONLY – PERSONAL INFORMATION

CLIENT'S NAME:	DATE:
GUARDIAN'S NAME (IF APPLICABLE):	CLIENT'S HEMOGLOBIN TYPE:
ADDRESS:	CITY, ZIP:
CLIENT'S DATE OF BIRTH:	CLIENT'S SOCIAL SECURITY NUMBER:
CONTACT INFORMATION OF CLIENT OR GUARDIAN (IF APPLICABLE)	HOME PHONE: WORK: CELL: EMAIL:
NUMBER IN HOUSEHOLD:	NUMBER OF INDIVIDUALS LIVING IN HOME WITH SICKLE CELL DISEASE:
PROXY:	DIETARY RESTRICTIONS/ALLERGIES:

CURRENT EMPLOYMENT STATUS:
- ☐ Not Employed
- ☐ Underemployed
- ☐ Employed (Name of Employer:___________________)
  - ☐ Full Time
  - ☐ Part Time

INCOME SOURCE(S)(check all that apply):
☐ TANF ☐ Food Stamps ☐ SSI ☐ Child Support ☐ WIC
☐ Employment ☐ Spouse Job ☐ Parent Job ☐ SSDI ☐ Other
☐ SS Survivor Benefits ☐ Unemployment

GROSS INCOME:
Individual – Monthly $____________________
Household – Monthly $___________________

CURRENT DRIVER'S LICENSE:
☐ Yes
☐ No
State:

TRANSPORATION:
☐ Bus
☐ Drive
☐ Ride with someone

Please Mark the following areas of need in which you and your family will receive assistance fulfilling:

☐ Income ☐ Employment ☐ Childcare ☐ Credit/Financial Literacy ☐ English Literacy Skills ☐ Career Resilience ☐ Life Skills
☐ Adult Education ☐ Support System ☐ Food ☐ Parenting Skills ☐ Family Relations ☐ Access to Services ☐ Health Care ☐ Mental Health
☐ Substance Abuse ☐ Transportation ☐ Safety ☐ Legal ☐ Clothing

Month	Date	Pantry	Gatorade	Date	P	G
January		☐	☐		☐	☐
February		☐	☐		☐	☐
March		☐	☐		☐	☐
April		☐	☐		☐	☐
May		☐	☐		☐	☐
June		☐	☐		☐	☐
July		☐	☐		☐	☐
August		☐	☐		☐	☐
September		☐	☐		☐	☐
October		☐	☐		☐	☐
November		☐	☐		☐	☐
December		☐	☐		☐	☐

I certify that all information in this application is true and correct to the best of my knowledge and I authorize the verification of the information I have provided. I understand that that my information will be used only by Martin Center Sickle Cell Initiative to provide optimum assistance, to identify and verify my records in the database system and for statistical program evaluation and reporting. I understand that I could be terminated from the service if I am found ineligible after enrollment. I will allow Martin Center Sickle Cell Initiative to share information about me and my training progress to any agency that has referred me to this service, outside agencies I am associated with or any agencies to which they may refer me for services or employment. My rights and responsibilities as an applicant or participant have been presented to me.

Client or Guardian (if Applicable) Signature:	Date:
MCSCI USE ONLY	
MCSCI Staff Signature:	Date:
MCSCI President/CEO Signature:	Date:
FPS Application Number: FPS-D 2016 -	Approved: ☐ Denied: ☐

MARTIN CENTER
SICKLE CELL INITIATIVE

Food Pantry Service Application

TRAIT ONLY – PERSONAL INFORMATION	
CLIENT'S NAME:	DATE:
GUARDIAN'S NAME (If applicable):	CLIENT'S HEMOGLOBIN TYPE:
ADDRESS:	CITY, ZIP:
CLIENT'S DATE OF BIRTH:	CLIENT'S SOCIAL SECURITY NUMBER:
CONTACT INFORMATION OF CLIENT OR GUARDIAN (If applicable)	HOME PHONE: WORK: CELL: EMAIL:
NUMBER IN HOUSEHOLD:	DIETARY RESTRICTIONS OR ALLERGIES:
PROXY:	INCOME SOURCE(S): ☐ TANF ☐ Food Stamps ☐ SSI ☐ Child Support ☐ WIC ☐ Employment ☐ Spouse Job ☐ Parent Job ☐ SSDI ☐ Other ☐ SS Survivor Benefits ☐ Unemployment
CURRENT EMPLOYMENT STATUS: ☐ Not Employed ☐ Underemployed ☐ Employed (Name of Employer: ___________________) ☐ Full Time ☐ Part Time	Gross Monthly Income: Individual$ Household $

Please Mark the following areas of need in which you and your family will receive assistance fulfilling:

☐ Income ☐ Employment ☐ Childcare ☐ Credit/Financial Literacy ☐ English Literacy Skills ☐ Career Resilience ☐ Life Skills
☐ Adult Education ☐ Support System ☐ Food ☐ Parenting Skills ☐ Family Relations ☐ Access to Services ☐ Health Care ☐ Mental Health
☐ Substance Abuse ☐ Transportation ☐ Safety ☐ Legal ☐ Clothing

Current Divers license?: ☐ Yes ☐ No State:	Transportation: ☐ Bus ☐ Drive ☐ Ride with someone

Month	Date	Pantry	Comments
January		☐	
February		☐	
March		☐	
April		☐	
May		☐	
June		☐	
July		☐	
August		☐	
September		☐	
October		☐	
November		☐	
December		☐	

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Client Signature:	Date:
MCSCI USE ONLY	
MCSCI Staff Signature:	Date:
MCSCI President/CEO Signature:	Date:
FPS Application Number: FPS-T 2016 -	Approved: ☐ Denied: ☐