



Humanitarian Service Project

Serving Humanity Since 1979

465 Randy Road - Carol Stream, IL 60188

630 221-8340 / FAX 630 221-8371

hsp@hsp.agency

www.hsp.agency

APPLICATION FORM FOR SENIORS

(Updated 08/2024)

Please print and include as much detail as possible when filling out application.

Name : _____ Date: _____

Phone: _____ Cell Phone: _____

Address: _____

City: _____ Zip Code: _____ Birth Date: _____

Email: _____

Monthly Income & Expenses:

Social Security: \$ _____ * If you receive other income, please

Pension: \$ _____ explain:

Other: \$ _____ _____

Total: \$ _____ _____

Do you: Rent Own home: How long have you lived at current address? _____

Monthly Rent/Mortgage: \$ _____ Monthly Utilities: \$ _____ Medical \$ _____

Do you own a car? Yes No Monthly car expenses \$ _____

Monthly Cable \$ _____ Cell Phone \$ _____

Marital status: Single Married Widowed Divorced Other

Race: White African American Asian American Indian

Other: _____

Are you a United States Armed Forces Veteran? Yes No

This monthly delivery consists of approx. 35 lbs of fresh produce, approx. 10 lbs of meat, 5 bags of non-perishables, and a bag of paper products, adding an additional 40 lbs; additionally, you will receive a bag of personal care items every three months. We calculate this will cover your groceries for 3 - 4 weeks. Can you handle 100 pounds of food and prepare it? Yes No

STAFF ONLY ID# _____

Date Entered _____

Initials _____

Do you live alone? Yes No If no, who lives with you?
(If more than 2, please attach a separate page with the information that is request below.)

Name: _____	Age: _____	Name: _____	Age: _____
Occupation: _____	Income: _____	Occupation: _____	Income: _____
Relationship: _____		Relationship: _____	

Do you have any pets? Yes No

Type of Animal: _____ Breed: _____ Name: _____
Type of Animal: _____ Breed: _____ Name: _____
Type of Animal: _____ Breed: _____ Name: _____

Do you currently receive services from any other organizations? (Does not mean you are ineligible for our program.) _____

Do you have a homemaker? Yes No

If yes, how often do they visit? _____

Family & Friends

Two People We Can Contact In An Emergency: VERY IMPORTANT

Name: _____	Home Phone: _____
Address: _____	Cell Phone: _____
_____	Relationship: _____
Name: _____	Home Phone: _____
Address: _____	Cell Phone: _____
_____	Relationship: _____

Number of Children: _____

(If you have more than 4 children, please attach a separate page with the information that is request below.)

Name: _____ Frequency of contact: Daily Weekly

Phone: _____ Monthly Yearly Seldom

Address: _____

Name: _____ Frequency of contact: Daily Weekly

Phone: _____ Monthly Yearly Seldom

Address: _____

Name: _____ Frequency of contact: Daily Weekly

Phone: _____ Monthly Yearly Seldom

Address: _____

Name: _____ Frequency of contact: Daily Weekly

Phone: _____ Monthly Yearly Seldom

Address: _____

Do any of your children provide you with any support? Yes No

If yes, please describe what help you receive (financial, groceries, rides to store or doctor, other) _____

If no, please explain: _____

Number of Siblings: _____

Contact with Siblings: Weekly Monthly Seldom Never

Do any of your siblings provide you with any support? Yes No

If yes, please list their name, phone number and address describe what help you receive (financial, groceries, rides to store or doctor, other):

Name: _____ Frequency of contact: Daily Weekly

Phone: _____ Monthly Yearly Seldom

Address: _____

Support: _____

Name: _____ Frequency of contact: Daily Weekly

Phone: _____ Monthly Yearly Seldom

Address: _____

Support: _____

If no, please explain _____

Current Monthly Grocery Situation:

How do you currently get your groceries? _____

Do you currently use a food pantry? _____

How much do you spend on average on groceries each month? _____

Do you ever have to skip meals or cut back because you cannot afford the food?

Do you have any dietary restrictions or food allergies?

Physical Condition: Please list all health problems or challenges for which you are being treated, plus those which are chronic for which you may not be receiving treatment or medication:

Do you use incontinence protection products such as Depends? Yes No
If yes, what style (such as pull-on, side tape, or liners) and size product do you use?

What are your monthly medical expenses - prescription drugs, insurance etc.?

Are you diabetic? Yes No Do you have any **food** allergies? Yes No

List Food Allergies: _____

Do you have any **dietary restrictions**? Yes No

List Dietary Restrictions: _____

Personal Information:

Hobbies: _____

Favorite Foods: _____

Favorite Color: _____ Favorite Flower: _____

Wish List of any items you need around the house or for yourself: _____

Additional Services:

Secret Pal Request: Would you be interested in having a Secret Pal, someone who sends cards, gifts, etc. on a regular basis? Yes No

If yes, do you give us permission to release your name, address, and phone number to our Volunteer Coordinator? Yes No

Any Special Directions to Your Home such as location in apartment complex, buzzer information, etc. (for Grocery Delivery purposes):

Is there any other information you believe we should know?

Recommended to our program by: _____

Title: _____ Telephone: _____

E-mail: _____

Release:

I grant the right for the Humanitarian Service Project to use the information from this Application along with my first name, but not my full name or address, for all uses related to the Humanitarian Service Project's mission and waive the right to inspect or approve any such use.

Senior Signature

I do affirm that the information above is correct and true to the extent of my knowledge.

Signature: _____ Date: _____