**Brandon Friendship Centre Inc.**

**Food Hamper Form**

Client #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouses Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Message Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many people reside in your household? \_\_\_\_Adults \_\_\_\_Children

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First Name Last Name M/F Age

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First Name Last Name M/F Age

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First Name Last Name M/F Age

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First Name Last Name M/F Age

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First Name Last Name M/F Age

[ ] Aboriginal [ ] Metis [ ]  Non-Status [ ]  Inuit [ ] Non-Aboriginal

Marital Status: [ ] Single [ ] Married/Common Law [ ] Divorced [ ] Widowed

Do you have any family supports, community supports or any other supports that you currently utilize? [ ] Yes [ ] No

If so what are they?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Source of income: [ ] Employed [ ] EIA Recipient [ ] EI [ ] Retired/Pension

Do you receive any of the following?

[ ] Child tax benefit [ ] GST benefit [ ] Canada worker benefit [ ] 55 Plus supplement [ ] Widows pension [ ] EIA supplement [ ] Guaranteed income supplement [ ] Rent assist [ ] CPP [ ] OAS [ ] Disability

Health Concerns: [ ] Diabetes [ ] COPD/Respiratory illness/Asthma

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

Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Allergies: [ ] Yes [ ] No

If so what are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have mobility issues? [ ] Yes [ ] No

Additional notes

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| --- |
| **Office use only**Client #:\_\_\_\_\_\_\_\_\_\_\_\_Hamper #:\_\_\_\_\_\_\_\_\_\_\_BFC Member: [ ] Yes [ ] No |