

**CITY MISSION SOCIETY of BOSTON**

14 Beacon Street, Suite 203  
Boston, Massachusetts 02108  
June R. Cooper, Executive Director



**INTAKE FORM FOR A LIFT UP CANDIDATES 2011**

**Tel: (617) 742-6830 x205**  
**FAX: (617) 742-8470**  
**Email: [information@cmsboston.org](mailto:information@cmsboston.org)**

Name of Referring Source: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_

Contact number and email: \_\_\_\_\_

\_\_\_\_\_

Name of Referral: \_\_\_\_\_

Contact number and/or email: \_\_\_\_\_

Is the client a resident of Boston: **yes** or **no**

Current Housing Status (where is the client housed, is there back rent, etc.): \_\_\_\_\_

\_\_\_\_\_

Is client systems involved? (examples: DCF, criminal records, paroled) If so please list below: \_\_\_\_\_

\_\_\_\_\_

Number of children dependent on client and ages: \_\_\_\_\_

\_\_\_\_\_

Is the client employed? If so, how? \_\_\_\_\_

Please list to your knowledge all sources of income for client: \_\_\_\_\_

\_\_\_\_\_

Is the client receiving any benefits?

TAFDC       WIC       SNAP       Fuel Assistance       Food Stamps

Child Support       SSI/SSDI       Other (please specify): \_\_\_\_\_

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Brief statement describing the needs of this client and why they would be appropriate for this program:

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**PLEASE RETURN BY FAX OR MAIL**

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