

Worker Interview Form

APPLICANT'S LEGAL NAME		CASE NUMBER
DATE APPLICATION SIGNED	DATE OF INTERVIEW	INTERVIEWER NAME
INTERPRETER USED? ☐ Yes ☐ No If yes, ☐ Client provided ☐ County provided		WORKER NAME

Applicant eligible for Expedited Food Support benefits? ☐ Yes ☐ No	
Comments/verification: <i>Same day interview offered?</i> ☐ Yes ☐ No <i>Client declined?</i> ☐ Yes ☐ No	

Household composition:

NAME	PROGRAMS APPLYING FOR	INTENDS TO RESIDE IN MN	MEMB, MEMI TYPE, PROG, SPON,	
			IMMIGRATION STATUS	SPONSOR
PERSON #1	☐ None ☐ Cash ☐ Food support ☐ Emergency ☐ Health care	☐ Yes ☐ No		☐ Yes ☐ No
PERSON #2	☐ None ☐ Cash ☐ Food support ☐ Emergency ☐ Health care	☐ Yes ☐ No		☐ Yes ☐ No
PERSON #3	☐ None ☐ Cash ☐ Food support ☐ Emergency ☐ Health care	☐ Yes ☐ No		☐ Yes ☐ No
PERSON #4	☐ None ☐ Cash ☐ Food support ☐ Emergency ☐ Health care	☐ Yes ☐ No		☐ Yes ☐ No
PERSON #5	☐ None ☐ Cash ☐ Food support ☐ Emergency ☐ Health care	☐ Yes ☐ No		☐ Yes ☐ No
PERSON #6	☐ None ☐ Cash ☐ Food support ☐ Emergency ☐ Health care	☐ Yes ☐ No		☐ Yes ☐ No
PERSON #7	☐ None ☐ Cash ☐ Food support ☐ Emergency ☐ Health care	☐ Yes ☐ No		☐ Yes ☐ No
PERSON #8	☐ None ☐ Cash ☐ Food support ☐ Emergency ☐ Health care	☐ Yes ☐ No		☐ Yes ☐ No

SPONSOR	
NAME	ADDRESS
NAME	ADDRESS

Comments/verification:

Instructions: If client answered “Yes” to any of the corresponding questions on the application, request the information listed under the question on the interview form and record any pertinent information in the “Comments/verification” section. If client answered “No” on the application, you do not have to complete the corresponding section on the interview form. Follow-up and document any inconsistent information in the comments/verification sections.

1. Is there anyone in your household who does not buy, fix or eat food with you?

If Yes, complete:

EATS

NAME	NAME

Comments/verification:

2. Is anyone in the household, who is age 60 or over or disabled, unable to buy or fix food due to a disability?

If Yes, complete:

EATS

NAME	NAME

Comments/verification:

3. Is anyone in the household attending school?

If Yes, complete:

SCHL

NAME	GRADE	NAME OF SCHOOL	STUDENT STATUS
			☐ Part time ☐ Full time
			☐ Part time ☐ Full time
			☐ Part time ☐ Full time
			☐ Part time ☐ Full time
			☐ Part time ☐ Full time
			☐ Part time ☐ Full time

Comments/verification:

4. Is anyone temporarily not living in your home?

If Yes, complete:

REMO

NAME	DATE	PLACE/ADDRESS WHILE OUT OF HOME	EXPECTED DATE OF RETURN

Comments/verification:

5. Did **anyone** move in or out of your home in the past 12 months?

If Yes, complete:

ADME, REMO

NAME	RELATIONSHIP TO YOU OR YOUR CHILDREN	DATE MOVED IN	DATE MOVED OUT

Comments/verification:

6. Is **either** parent of any children under age 19 dead, or not living in the home?

If Yes, complete:

INFC/CSIA, ABPS

ABSENT PARENT'S NAME	CHILD'S NAME	DOES PARENT VISIT OR SHARE CUSTODY
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Comments/verification:

Referral made to Child Support and Collections?

☐ Yes ☐ No

7. Is **anyone** mentally or physically ill, disabled or not able to care for themselves?

If Yes, complete:

DISA

NAME	MEDICAL PROBLEM	DATE MEDICAL PROBLEM STARTED

Comments/verification:

Verification: ☐ requested ☐ attached

8. Is **anyone** unable to work for reasons other than illness or disability?

If Yes, complete:

WREG, EMPS

NAME	REASON

Comments/verification:

Verification: ☐ requested ☐ attached

9. Is the last 90 days did **anyone** in the household quit a job or stop working, refuse a job offer, ask to work fewer hours, or go on strike?

If Yes, complete:

STWK, STRK

PERSON'S NAME	REASON	DATE OF ACTION

Comments/verification:

Verification: ☐ requested ☐ attached

10. Has **anyone** in the household been injured or had an accident in the past 72 months?

If Yes, complete:

ACCI

PERSON'S NAME	DATE OF ACCIDENT OR INJURY	TYPE OF ACCIDENT/INJURY

Comments/verification:

Verification: ☐ requested ☐ attached

11. Is **anyone** in the household on a diet prescribed by a doctor?

If Yes, complete:

DIET

NAME	TYPE OF DIET

Comments/verification:

Verification: ☐ requested ☐ attached

Assets

12. Does **anyone** in the household own, or is anyone buying, any of the following types of assets? If Yes, complete:

TYPE OF PROPERTY		OWNER(S) NAME	TOTAL VALUE
Cash	CASH		
Accounts such as checking, savings, debit cards, money market, trust funds, annuities, certificates of deposit (CD), retirement funds ACCT	Type(s):		
Stocks, bonds, annuities, contracts for deed or other securities SECU			
Life insurance or burial accounts SECU, OTHR			
Vehicles such as cars, trucks, campers, motorcycles (specify make/model/year) CARS			
Other assets such as tools, livestock, boats, motors, trailers, farm implements, snowmobiles OTHR			
Land, buildings, life estates, houses, mobile homes REST			
Sponsor's assets (if client is not a U.S. citizen) SPON			

Comments/verification:	Verification: ☐ requested ☐ attached

13. Has **anyone** in the household given away, sold or traded anything of value **in the past 60 months?** If Yes, complete:

					TRAN
TYPE(S) OF PROPERTY	ITEM(S) TRANSFERRED	PERSON WHO TRANSFERRED PROPERTY	PERSON WHO RECEIVED PROPERTY	VALUE OF PROPERTY	DATE OF TRANSFER
Land, buildings, mobile homes, life estates, waived right to an inheritance					
Cash, bank accounts, stocks, bonds, contracts for deed, annuities, trust funds					
Property such as burial funds, vehicles or other assets					

Comments/verification (Question 13):

Verification: ☐ requested ☐ attached

Income

14. Has **anyone** in the household had a job in the past 12 months?

If Yes, complete:

JOBS

NAME	EMPLOYER	DATE STARTED	DATE STOPPED

Comments/verification:

Verification: ☐ requested ☐ attached

15. Does **anyone** in the household have a job or expect to get income from a job this month or next month? (Request verification or complete table below.)

If Yes, complete:

JOBS, STIN

#1 This month's work income	NAME	JOB BEGIN DATE		
EMPLOYER NAME	EMPLOYER ADDRESS			
HOW OFTEN PAID? ☐ Daily ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Other _____		PAY RATE	# HOURS PER WEEK	DATE LAST CHECK REC'D
DATE CHECK RECEIVED	GROSS AMOUNT	TIPS/COMMISSION	HOURS WORKED	
1st				
2nd				
3rd				
4th				
5th				
Next month's expected work income	GROSS INCOME	EXPECTED TIPS/COMMISSION	TOTAL INCOME	EXPECTED HOURS

Comments/verification (Question 15):

Verification: ☐ requested ☐ attached

#2 This month's work income	NAME		JOB BEGIN DATE	
EMPLOYER NAME		EMPLOYER ADDRESS		
HOW OFTEN PAID? ☐ Daily ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Other _____		PAY RATE	# HOURS PER WEEK	DATE LAST CHECK REC'D
DATE CHECK RECEIVED	GROSS AMOUNT	TIPS/COMMISSION	HOURS WORKED	
1st				
2nd				
3rd				
4th				
5th				
Next month's expected work income	GROSS INCOME	EXPECTED TIPS/COMMISSION	TOTAL INCOME	EXPECTED HOURS

Does the household have other sources of income from a job? ☐ Yes ☐ No

Comments/verification:

Verification: ☐ requested ☐ attached

16. Does anyone in the household self-employed or does anyone expect to get income from self-employment this month or next month?

If Yes, complete:

BUSI, RBIC

PERSON'S NAME		DATE SELF-EMPLOYMENT BEGAN	HOURS WORKED PER MONTH
KIND OF BUSINESS		OWNERSHIP ☐ Individual ☐ Partnership ☐ Corporation	
This month	GROSS INCOME	AMOUNT OF EXPENSES	
Last calendar year	GROSS INCOME	AMOUNT OF EXPENSES	

Does the client have other sources of self-employment income? ☐ Yes ☐ No

Do the net business assets of all businesses total \$200,000 or less? ☐ Yes ☐ No

Comments/verification (Question 16):

Verification: ☐ requested ☐ attached

17. Do you expect any changes in income, expenses or work hours?

EXPLAIN:

18. Has **anyone** in the household applied for or does anyone get any unearned income?

If Yes, complete:

PBEN, UNEA

TYPE OF UNEARNED INCOME		AMOUNT OF LAST CHECK RECEIVED	PERSON WHO RECEIVED CHECK	DATE STARTED	DATE STOPPED
Social Security (RSDI)					
Supplemental Security Income (SSI)					
Veteran benefits (VA)					
Unemployment Insurance					
Workers' Compensation					
Retirement benefits					
Child support or spousal support					
Other unearned income such as: contract for deed, interest/dividends, rental, gifts or loans, sponsor's income (for non-citizens), lump sums, gambling winnings, annuities, trusts	(list type of other income)				

Comments/verification:

Verification: ☐ requested ☐ attached

19. Does **anyone** in the household have or expect to get any loans, scholarships or grants for attending school?

If Yes, complete:

STIN

Comments/verification:

Verification: ☐ requested ☐ attached

Expenses

20. Does **your household** have the following housing expenses?

If Yes, complete:

SHEL, EATS

TYPE OF HOUSING EXPENSE	AMOUNT OF HOUSING EXPENSE	PERSON BILLED	IF SHARED, HOW MUCH DOES EACH PERSON PAY?
Rent (include mobile home lot rental)			
Mortgage/contract for deed payment			
Association fees			
Homeowner's insurance (if not included in mortgage)			
Real estate taxes (if not included in mortgage)			
Room and/or meals			

Is the client billed for garage rent? ☐ Yes ☐ No

Does the client live in **subsidized** housing? ☐ Yes ☐ No

Does the client expect a change in housing costs? ☐ Yes ☐ No
When? _____ What? _____

Are housing costs shared with anyone? ☐ Yes ☐ No
Who? _____ What cost(s)? _____

Comments/verification:

Verification: ☐ requested ☐ attached

21. Does your household have the following utility expenses **any time** during the year?

If Yes, complete:

ACUT, HEST

TYPE OF UTILITY EXPENSE	AMOUNT OF BILL	PERSON BILLED	HOW MUCH DOES EACH PERSON PAY?
Heating and/or A/C			
Electricity			
Cooking fuel			
Garbage removal			
Water and sewer			
Phone			

Does the client have central or window air conditioning in their home?

☐ Yes ☐ No

If yes, do they ever use it?

☐ Yes ☐ No

Is household responsible to pay A/C costs?

☐ Yes ☐ No

Does the client want Food Support benefits figured using the standard or actual utility amounts?

☐ Standard utility amount **or** ☐ Actual utility costs

Does client get Low Income Home Energy Assistance Program (LIHEAP) funds?

☐ Yes ☐ No

Comments/verification:

Verification: ☐ requested ☐ attached

22. Child or adult care: Do you or anyone living with you have costs for care of a child or an ill or disabled adult because you or they were working, looking for work or going to school? If Yes, complete:

DCEX

NAME OF PERSON GETTING CARE	AMOUNT CLIENT PAID FOR CURRENT MONTH	AMOUNT PAID BY SOMEONE ELSE FOR CURRENT MONTH	NAME OF PERSON GIVING CARE
1.			
2.			
3.			
4.			

Comments/verification:

Verification: ☐ requested ☐ attached

23. Does anyone in the household pay court-ordered child support, spousal support, child care support, medical support or contribute to a tax dependent who does not live in your home?

If Yes, complete:

COEX

NAME OF PERSON MAKING PAYMENT	TYPE OF PAYMENT	MONTHLY AMOUNT

Comments/verification:

Verification: ☐ requested ☐ attached

24. Does anyone in the household have expenses related to work, training or job search, such as transportation, meals or uniforms?

If Yes, complete:

WKEX

Comments/verification:	Verification: ☐ requested ☐ attached
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25a. Does anyone in your household currently have health insurance or prescription drug coverage?

If Yes, complete:

INSA

Has anyone had coverage in the past 4 months?

☐ Yes ☐ No If yes:

NAME	KIND OF COVERAGE

Does anyone in client's household work for an employer who currently offers health insurance or has offered health insurance in the past?

☐ Yes ☐ No If yes:

NAME	KIND OF COVERAGE

If any member of the household is a college student, can they get health insurance through their parents or through the school?

☐ Yes ☐ No If yes:

NAME	KIND OF COVERAGE

Comments/verification:

25b. Does **anyone in** your household have Medicare Part A, B or D?

If Yes, complete:

MEDI

NAME	MEDICARE ID NUMBER	START DATE

Comments/verification:

26. Proof of medical expenses:

FMED, BILS

Food Support applicants or recipients: Before allowing a medical deduction, request proof of all recurring medical bills incurred by anyone in client's household who is disabled or 60 years or older. Do not count medical bills that are being paid for by any health care program, insurance or someone not living in client's household.

Health care program applicants or recipients: Some health care programs may pay for health care the client received up to three months before client applied for help. Request proof of any medical bills the client or any household member incurred in the last three months.

What month would client like health care coverage to start?

Comments/verification:

Verification: ☐ requested ☐ attached

Client given:

- | | | |
|--|---|--|
| ☐ R & R (tear off page on CAF) | ☐ Notice of Privacy Practices (DHS-3979) | ☐ ADA brochure (DHS-4133) |
| ☐ Family Violence Referral (DHS-3323) | ☐ Change Report Form (DHS-2402) | ☐ Important Information sheet (DHS 5223B) |
| ☐ Domestic Violence Information Brochure (DHS-3477) | | |

Program eligibility summary

PERSON #	CASH	FOOD SUPPORT	HEALTH CARE	OTHER	COMMENTS
1					
2					
3					
4					
5					
6					
7					
8					