Catholic Family Support Services
Keeping Hope Alive

Date Entered:	
Referral Date:	
Financial Mentor:	

Email to: admin@cfss.org.nz or diannel@cfss.org.nz

First appointment: Date: | Time:

Presenting Client's Details:

Client Name:		Date of Birth:	
Address:			
		Postcode:	
Ethnicity:		Iwi:	
Country of Birth:		Gender:	
Referred by:		Agency:	
Referrers Email Address:			

Phone number:		Cellphone:	
Email address:			
Income Type:			
Work & Income No.			
Client Issues:			

Housing [please tick the appropriate category]

Renting or Flatting		Renting to Housing NZ	
Own home with mortgage		Shared Housing/Boarding	
Own home Freehold		Other	
No. of bedrooms in home			

Family Composition

Name	Date of Birth	Gender	
		M	F
		M	F
		M	F
		M	F
		M	F
		M	F
		M	F

Previous Financial Mentoring Advice	Yes	No	If Yes, who with?	

I, _____ confirm that it has been explained to me That CFSS will communicate with the Referring Agency regarding my engagement with our services (if applicable).

Client Waiver

In accordance with the Privacy Act 1993, Principles 3(b) and 11(d), I understand that this information is to be recorded. It has also been explained to me that my file may be inspected by a representative of our contract provider for the purposes of a quality review of this service. I also understand that the Ministry of Social Development (MSD) may request my file be transferred to either themselves or another budgeting provider if our service ceases to operate.

Client Signature _____ Date _____ Financial Mentor Signature _____ Date _____