

Agency: \_\_\_\_\_ Staff Name: \_\_\_\_\_ County: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

CLIENT INTAKE FORM

Family Type: (Check One)

- ( ) Single/Unaccompanied Female ( ) Single/Unaccompanied Male ( ) Female w/ children
( ) Male w/ children ( ) Couple w/o children ( ) Couple w/ children

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_
Social Security Number: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Veteran: ( ) Yes ( ) No
Gender: ( ) Male ( ) Female ( ) Transgender-FTM ( ) Transgender-MTF Ethnicity: ( ) Hispanic ( ) Non-Hispanic
Race: ( ) Asian ( ) Black/African American ( ) American-Indian/Alaskan ( ) White ( ) Pacific Islander ( ) Other

Housing Status:

- ( ) Homeless ( ) At imminent risk of losing housing ( ) Homeless only under other federal statutes
( ) Fleeing domestic violence ( ) At-risk of homelessness ( ) Stably housed

Last Permanent Address (Resided for 90+ days) City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
Disabling Condition: ( ) Yes ( ) No Chronically Homeless: ( ) Yes ( ) No

Prior Night's Residence:

- ( ) Emergency shelter, including hotel or motel paid for with emergency shelter voucher
( ) Foster care home or foster care group home
( ) Hospital or other residential non-psychiatric medical facility
( ) Hotel or motel paid for without emergency shelter voucher
( ) Jail, prison or juvenile detention facility
( ) Long-term care facility or nursing home
( ) Owned by client, no housing subsidy
( ) Owned by client, with housing subsidy
( ) Permanent housing for formerly homeless persons (such as SHP, S+C, or SRO Mod Rehab)
( ) Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/subway station/airport or anywhere outside)
( ) Psychiatric hospital or other psychiatric facility
( ) Rental by client, no housing subsidy
( ) Rental by client, with VASH housing subsidy
( ) Rental by client, with other (non VASH) housing subsidy
( ) Rental by client, with GPD TIP subsidy
( ) Residential project or halfway house with no homeless criteria
( ) Safe Haven
( ) Staying or living in a family member's room, apartment or house
( ) Staying or living in a friend's room, apartment or house
( ) Substance abuse treatment facility or detox center
( ) Transitional housing for homeless persons (including homeless youth)
( ) Other

Length of Stay (in last night's residence):

- ( ) One day or less ( ) Two days to one week ( ) More than one week, but less than one month
( ) One to three months ( ) More than three months, but less than a year ( ) One year or longer

Entering from the streets, emergency shelter or safe haven: ( ) Yes ( ) No

If Yes, actual or approximate date started: \_\_\_\_\_

Times Homeless Past Three Years: ( ) Never ( ) 1 ( ) 2 ( ) 3 ( ) 4 or more

If more than once, how many months homeless in the Past Three Years:

- ( ) 0 ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) 6 ( ) 7 ( ) 8 ( ) 9 ( ) 10 ( ) 11 ( ) 12 ( ) More than 12 months

(For RRH Projects) Are you in Permanent Housing? ( ) Yes ( ) No If Yes, Move In Date: \_\_\_\_\_

**Special Needs: Check ONE answer for each criterion**

<b>Substance abuse</b>	<input type="checkbox"/> No	<input type="checkbox"/> Both alcohol & drug abuse	<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Drug abuse
	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't know	<input type="checkbox"/> Refused
<i>Long Duration?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Refused
<i>Receiving/received treatment?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Refused
<b>Physical disability</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't know	<input type="checkbox"/> Refused
	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Refused
<i>Long Duration?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Refused
<i>Receiving/received treatment?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Refused
<b>Mental illness</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't know	<input type="checkbox"/> Refused
	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Refused
<i>Long Duration?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Refused
<i>Receiving/received treatment?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Refused
<b>Illiterate or marginally literate</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't know	<input type="checkbox"/> Refused
<b>HIV/AIDS and related diseases</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't know	<input type="checkbox"/> Refused
	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Refused
<i>Long Duration?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Refused
<i>Receiving/received treatment?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Refused
<b>Domestic violence</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't know	<input type="checkbox"/> Refused
<i>Experience occurred:</i>	<input type="checkbox"/> Within the past 3 months	<input type="checkbox"/> 3 to 6 months ago	<input type="checkbox"/> More than a year ago	
	<input type="checkbox"/> 6 to 12 months ago	<input type="checkbox"/> More than a year ago		
	<input type="checkbox"/> Don't know	<input type="checkbox"/> Refused		
<b>Developmental disability</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't know	<input type="checkbox"/> Refused
	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Refused
<i>Long Duration?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Refused
<i>Receiving/received treatment?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Refused
<b>Chronic Health Condition</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't know	<input type="checkbox"/> Refused
	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Refused
<i>Long Duration?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Refused
<i>Receiving/received treatment?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Refused

**Income and Non-Cash Benefits Information**

Income Sources	Amount	Date Started	Whose Income?
<input type="checkbox"/> Earned Income:			
<input type="checkbox"/> Unemployment Insurance:			
<input type="checkbox"/> Supplemental Insurance Security (SSI)			
<input type="checkbox"/> Social Security Disability Income (SSDI)			
<input type="checkbox"/> VA Service-Connected Disability Compensation			
<input type="checkbox"/> Private Disability Insurance			
<input type="checkbox"/> Workers Compensation			
<input type="checkbox"/> Temporary Assistance for Needy Families			
<input type="checkbox"/> General Assistance			
<input type="checkbox"/> Retirement Income from SS			
<input type="checkbox"/> VA Non-Service-Connected Disability Pension			
<input type="checkbox"/> Pension or retirement income from former job			
<input type="checkbox"/> Child Support			
<input type="checkbox"/> Alimony or other special support			
<input type="checkbox"/> Other source			

**Total Monthly Income** \_\_\_\_\_

<b>Non-Cash Benefit Sources</b>	<b>Amount</b>	<b>Date Started</b>	<b>Whose Income?</b>
( ) Supplemental Nutrition Assistance Program (SNAP)			
( ) Special Supplemental Nutrition for Women, Infants & Children (WIC)			
( ) Supplemental Insurance Security (SSI)			
( ) TANF Child Care Services			
( ) TANF Transportation			
( ) Other TANF funded services			
( ) Section 8, public housing, or other ongoing rental assistance			
( ) Temporary Assistance for Needy Families			
( ) Other Source			
( ) Temporary Rental Assistance			

<b>Health Insurance</b>				
( ) Medicaid Health Insurance	( ) Applied; Decision Pending	( ) Applied; Not eligible	( ) Did Not Apply	( ) N/A Insurance Type
( ) Medicare Health Insurance	( ) Applied; Decision Pending	( ) Applied; Not eligible	( ) Did Not Apply	( ) N/A Insurance Type
( ) State Children’s Health Insurance	( ) Applied; Decision Pending	( ) Applied; Not eligible	( ) Did Not Apply	( ) N/A Insurance Type
( ) Veterans Administration (VA) Medical Services	( ) Applied; Decision Pending	( ) Applied; Not eligible	( ) Did Not Apply	( ) N/A Insurance Type
( ) Employer Provided Health Insurance	( ) Applied; Decision Pending	( ) Applied; Not eligible	( ) Did Not Apply	( ) N/A Insurance Type
( ) Health Insurance Obtained through COBRA	( ) Applied; Decision Pending	( ) Applied; Not eligible	( ) Did Not Apply	( ) N/A Insurance Type
( ) Private Pay Health Insurance	( ) Applied; Decision Pending	( ) Applied; Not eligible	( ) Did Not Apply	( ) N/A Insurance Type
( ) State Health Insurance for Adults	( ) Applied; Decision Pending	( ) Applied; Not eligible	( ) Did Not Apply	( ) N/A Insurance Type

**\*IF THERE ARE ADDITIONAL HOUSEHOLD MEMBERS, PLEASE COMPLETE THE HOUSEHOLD MEMBER INTAKE FORM FOR EACH ADDITIONAL MEMBER.**