



# Community Action North Bay

## Intake Form

\*1. Name: \*First \_\_\_\_\_ \* Middle \_\_\_\_\_ \*Last \_\_\_\_\_ \*Suffix \_\_\_\_\_

\*2. Nickname/Alias \_\_\_\_\_ \*3. Maiden Name \_\_\_\_\_

\*4. Social Security Number \_\_\_\_\_ 5. \* Date of Birth \_\_\_\_\_ 6. Age \_\_\_\_\_

7. Place of Birth (City, State, Country) \_\_\_\_\_

\*8. Gender:  Male  Female  Transgender to male  Transgender to female

9. Phone Number(s) \_\_\_\_\_ 10. Email \_\_\_\_\_

\*11. Last Permanent Residence (where client last resided for 90 days or more)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ \*Zip Code \_\_\_\_\_

\*When did you leave? (M/D/Y) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

12. Current or Most Recent Mailing Address (if different from above) \*Are you currently staying there?  Yes  No

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

\*13. (a) Have you ever received services under another name?  Yes  No If so what name? \_\_\_\_\_

(b) Have you ever received services with another Social Security Number?  Yes  If so, what number? \_\_\_\_\_

\*14. Ethnicity  Hispanic/Latino  Other (non-Hispanic/Latino)

\*15. What BEST describes you? (Check all that apply) [Those of Latin heritage should mark American Indian if their ancestry is from North, South or Central America. Those from the Far East (including India) should mark Asian. Those from the Middle East should mark White.]

American Indian/Alaskan Native  Asian  Native Hawaiian/Pacific Islander

Black/African-American  White

16. Services Requested at Intake (Check all that apply):

Services Available	
<input type="checkbox"/> Transitional Housing	<input type="checkbox"/> Life Skills Training Classes
<input type="checkbox"/> Rental Assistance	<input type="checkbox"/> Transportation
<input type="checkbox"/> Utility Assistance	<input type="checkbox"/> Clothing Closet
<input type="checkbox"/> Emergency Food	<input type="checkbox"/> Payee Services
<input type="checkbox"/> Wednesday Surplus Food Program	<input type="checkbox"/> Computer Access
<input type="checkbox"/> Employment/Job Training	<input type="checkbox"/> Information & Referral
<input type="checkbox"/> Benefit Assistance	<input type="checkbox"/> Other

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**17. Who referred you to this program?**

- |   |   |                                    |
|---|---|------------------------------------|
| <input type="radio"/> Friend                        | <input type="radio"/> Law Enforcement/Police        | <input type="radio"/> Web/Internet |
| <input type="radio"/> Family Member                 | <input type="radio"/> Shelter                       | <input type="radio"/> Self         |
| <input type="radio"/> Hospital (non-psychiatric)    | <input type="radio"/> VA                            | <input type="radio"/> Other _____  |
| <input type="radio"/> Psychiatric hospital/facility | <input type="radio"/> Church/Religious Organization |                                    |
| <input type="radio"/> Criminal Justice system       | <input type="radio"/> Residential Program           |                                    |

**\*18. Housing Status at Program Entry: (Choose one)**

- Literally homeless* – client currently lives in an emergency shelter or place not meant for habitation, OR client stayed in a hospital or other institution for up to 30 consecutive days (180 for HPRP programs) and was sleeping in an emergency shelter/place not meant for habitation prior to entering the hospital or other institution.
- Housed and at imminent risk of losing housing* – client is being or has been evicted, kicked out, or discharged from an institution (where they have been a resident for more than 30 consecutive days). Additionally, no appropriate housing options have been identified and client lacks the resources needed to obtain housing or remain in their existing housing.
- Housed and at-risk of losing housing* – client is currently in their own housing or doubled up with friends/relatives but are at-risk of losing their housing due to high housing costs, conflict, or other conditions. Additionally, client lacks the resources needed to maintain or obtain housing. However client is not in immediate danger of becoming literally homeless.
- Stably housed* – client is in a stable housing situation and is not at-risk of losing this housing.

**\*19. Please check what best describes your living situation last night (prior to entering this program):**

- |  |   |   |
|--|---|---|
| <input type="radio"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher  | <input type="radio"/> Jail, prison, or juvenile detention facility                    | <input type="radio"/> Hotel or motel paid for without emergency shelter voucher                                       |
| <input type="radio"/> Transitional housing for homeless persons (including homeless youth)                 | <input type="radio"/> Rental by client, no housing subsidy                            | <input type="radio"/> Foster care home or foster care group home  |
| <input type="radio"/> Permanent housing for formerly homeless persons (such as SHP, S+C, or SRO Mod Rehab) | <input type="radio"/> Rental by client, with VASH housing subsidy                     | <input type="radio"/> Place not meant for habitation inclusive of “non-housing service site (outreach programs only)” |
| <input type="radio"/> Psychiatric hospital or other psychiatric facility                                   | <input type="radio"/> Rental by client, with other (non-VASH) housing subsidy         | <input type="radio"/> Other   |
| <input type="radio"/> Substance abuse treatment facility or detox center                                   | <input type="radio"/> Owned by client, no housing subsidy                             | <input type="radio"/> Safe haven  |
| <input type="radio"/> Hospital (non-psychiatric)   | <input type="radio"/> Owned by client, with housing subsidy                           |   |
|  | <input type="radio"/> Staying or living in a family member’s room, apartment or house |   |
|  | <input type="radio"/> Staying or living in a friend’s room, apartment or house        |   |

**\*20. Length of living situation prior to entering this program:**

- |   |  |  |
|---|--|--|
| <input type="radio"/> One week or less                            | <input type="radio"/> One to three months                            | <input type="radio"/> One year or longer |
| <input type="radio"/> More than one week, but less than one month | <input type="radio"/> More than three months, but less than one year |  |

**If less than 30 days, where were you living before?**

- Emergency Shelter  Other (see item 19 for best description) \_\_\_\_\_

**21. Estimate how much longer you expect to reside there**

- |  |   |  |  |
|--|---|--|--|
| <input type="radio"/> Can’t go back    | <input type="radio"/> It’s a day-by-day arrangement     | <input type="radio"/> Less than 3 months | <input type="radio"/> 3 months to a year |
| <input type="radio"/> More than a year | <input type="radio"/> Until shelter/housing is received | <input type="radio"/> No plans to change |  |

**\*22. How many times (other than now) within the past 3 years have you been without housing or stayed in an emergency shelter?**

- None  1 time  2 times  3 times  4 times  More than 4 (please specify) \_\_\_\_\_  Don’t Know

**\*23. Have you been continuously homeless for a year or more?  Yes  No**

**Note:** A chronically homeless individual has a disabling condition and has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency homeless shelter.

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**24. Cause of homelessness** (check all that apply):

- Divorce/Separation     Domestic Violence     Eviction     Loss of job     Low Income  
 Mental Illness     Parole     Ran Away     Rent increase     Substance Abuse  
 Thrown Out     Other \_\_\_\_\_

**\*25. Are you (and your dependent children) capable of self-care?**  Yes     Yes with assistance     No

**\*26. Have you ever served in the US Military?**  Yes     No

**\*27. Do you have a Disabling Condition?**     Yes     No

This means: Do you have a physical, mental, emotional, developmental disability, HIV/AIDS, diagnosable substance abuse problem, or chronic health condition of expected long duration that substantially limits your ability to live on your own?

**\*28. Disability Type?** Check all that apply. Indicate if it is expected to be of long duration & if client is currently receiving services for this condition.

	<u>Long Term?</u> <u>(Y/N)</u>	<u>Currently receiving</u> <u>services for this</u> <u>condition? (Y/N)</u>		<u>Long Term?</u> <u>(Y/N)</u>	<u>Currently receiving</u> <u>services for this</u> <u>condition?(Y/N)</u>
<input type="checkbox"/> Mental Illness	_____	_____	<input type="checkbox"/> Physical Disability	_____	_____
<input type="checkbox"/> Alcohol Abuse	_____	_____	<input type="checkbox"/> Developmental Disability	_____	_____
<input type="checkbox"/> Drug Abuse	_____	_____	<input type="checkbox"/> Chronic Health Condition	_____	_____
<input type="checkbox"/> HIV/AIDS and related diseases	_____	_____	<input type="checkbox"/> Other (Please specify)	_____	_____

**Note:** Chronic health condition - a diagnosed condition that is more than three months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples include but are not limited to: heart disease, severe asthma; diabetes; arthritis-related conditions; adult onset cognitive impairments (including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive related conditions); severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.

**\*29. Have you ever been a victim of domestic violence?**  Yes     No

If you answered Yes above, please indicate when the most recent domestic violence experience occurred:

Within the past 3 months     3-6 months ago     6 months-12 months ago     More than a year ago

**\*30. Household Configuration:**  Single     Family with Children     Family without Children     Other \_\_\_\_\_

**\*31. Are you the Head of Household?**  Yes     No

**32. How many children in your household?** \_\_\_\_\_

**33. What is your total household size?** \_\_\_\_\_



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**\*34. Please list information about all dependent children (under 18 years old) in your household.**  
 Add additional lines on back if more than 6 dependent children.

Name (Last, First Middle)	Birth Date	SS #	Program Entry Date (if diff. from above)	Gender	Ethnicity	Race	Disability/ Special Needs	Homeless Status (Refer to page 2)
				<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Hispanic <input type="radio"/> Other			
				<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Hispanic <input type="radio"/> Other			
				<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Hispanic <input type="radio"/> Other			
				<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Hispanic <input type="radio"/> Other			
				<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Hispanic <input type="radio"/> Other			
				<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Hispanic <input type="radio"/> Other			
				<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Hispanic <input type="radio"/> Other			

**\*35. Did all of these children reside with you at your last permanent address?**  Yes  No

**Do all of these children continue to live with you?**  Yes  No

**If no, please specify:** (where do they live and for how long)

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**\*36. Monthly Income:** (Check all that apply)

<u>Source</u>	<u>Any income received in the past 30 days? (Y/N)</u>	<u>Amount</u>	<u>Source</u>	<u>Any income received in the past 30 days? (Y/N)</u>	<u>Amount</u>
Ⓢ Earned Income	_____	_____	Ⓢ Alimony or Other spousal support	_____	_____
Ⓢ Retirement Income from Social Security	_____	_____	Ⓢ SSI	_____	_____
Ⓢ Pension from a former job	_____	_____	Ⓢ SSDI	_____	_____
Ⓢ Private disability insurance	_____	_____	Ⓢ General Assistance	_____	_____
Ⓢ Child Support	_____	_____	Ⓢ TANF	_____	_____
Ⓢ Unemployment insurance	_____	_____	Ⓢ Other	_____	_____
Ⓢ Workers Compensation	_____	_____	Ⓢ No Financial Resources	_____	_____
Ⓢ Veteran's Pension	_____	_____		_____	_____
Ⓢ Veteran's Disability payment	_____	_____		_____	_____

**\*37. Non-Cash Benefits:** (Check all that apply)

<u>Source</u>	<u>Any income received in the past 30 days? (Y/N)</u>	<u>Amount</u>	<u>Source</u>	<u>Any income received in the past 30 days? (Y/N)</u>	<u>Amount</u>
Ⓢ Food Stamps	_____	_____	Ⓢ State Children's Health Insurance Program (SCHIP)	_____	_____
Ⓢ TANF Child Care Services	_____	_____	Ⓢ Veteran Administration (VA) Medical Services	_____	_____
Ⓢ TANF Transportation Services	_____	_____	Ⓢ Section 8, Public Housing or rental assistance	_____	_____
Ⓢ Other TANF-funded services	_____	_____	Ⓢ WIC	_____	_____
Ⓢ Medicaid/MediCal	_____	_____	Ⓢ Other	_____	_____
Ⓢ Medicare	_____	_____		_____	_____

**\*38. Current Total Monthly Income** (for self and dependents under 18): \$ \_\_\_\_\_

**\*39. Emergency Contact** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

**I certify that I have read and understand all of the information that has been provided for me.  
I also certify that all the information that I provided today is true and correct.**

\_\_\_\_\_  
**Signature of Applicant**

\_\_\_\_\_  
**Date**