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	
® Transitional Housing	® Life Skills Training Classes
® Rental Assistance	® Transportation
® Utility Assistance	® Clothing Closet
® Emergency Food	® Payee Services
® Wednesday Surplus Food Program	® Computer Access
® Employment/Job Training	® Information & Referral
® Benefit Assistance	® Other

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17. Who referred you to this program?

- ⑧ Friend
- ⑧ Family Member
- ⑧ Hospital (non-psychiatric)
- ⑧ Psychiatric hospital/facility
- ⑧ Criminal Justice system
- ⑧ Law Enforcement/Police
- ⑧ Shelter
- ⑧ VA
- ⑧ Church/Religious Organization
- ⑧ Residential Program
- ⑧ Web/Internet
- ⑧ Self
- ⑧ Other _____

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

⑧ *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 habilitation prior to entering the hospital or other institution.

⑧ *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.

⑧ *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.

⑧ *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):**

- ⑧ Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- ⑧ Transitional housing for homeless persons (including homeless youth)
- ⑧ Permanent housing for formerly homeless persons (such as SHP, S+C, or SRO Mod Rehab)
- ⑧ Psychiatric hospital or other psychiatric facility
- ⑧ Substance abuse treatment facility or detox center
- ⑧ Hospital (non-psychiatric)
- ⑧ Jail, prison, or juvenile detention facility
- ⑧ Rental by client, no housing subsidy
- ⑧ Rental by client, with VASH housing subsidy
- ⑧ Rental by client, with other (non-VASH) housing subsidy
- ⑧ Owned by client, no housing subsidy
- ⑧ Owned by client, with housing subsidy
- ⑧ Staying or living in a family member's room, apartment or house
- ⑧ Staying or living in a friend's room, apartment or house
- ⑧ Hotel or motel paid for without emergency shelter voucher
- ⑧ Foster care home or foster care group home
- ⑧ Place not meant for habitation inclusive of "non-housing service site (outreach programs only)"
- ⑧ Other
- ⑧ Safe haven

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

- ⑧ One week or less
- ⑧ More than one week, but less than one month
- ⑧ One to three months
- ⑧ More than three months, but less than one year
- ⑧ One year or longer

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

⑧ Emergency Shelter ⑧ Other (see item 19 for best description) _____

21. Estimate how much longer you expect to reside there

⑧ Can't go back ⑧ It's a day-by-day arrangement ⑧ Less than 3 months ⑧ 3 months to a year
⑧ More than a year ⑧ Until shelter/housing is received ⑧ 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?**

⑧ None ⑧ 1 time ⑧ 2 times ⑧ 3 times ⑧ 4 times ⑧ More than 4 (please specify)_____ ⑧ Don't Know

***23. Have you been continuously homeless for a year or more?** ⑧ Yes ⑧ 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.

	Long Term? (Y/N)	Currently receiving services for this condition? (Y/N)		Long Term? (Y/N)	Currently receiving services for this condition?(Y/N)
⊗ Mental Illness	_____	_____	⊗ Physical Disability	_____	_____
⊗ Alcohol Abuse	_____	_____	⊗ Developmental Disability	_____	_____
⊗ Drug Abuse	_____	_____	⊗ Chronic Health Condition	_____	_____
⊗ HIV/AIDS and related diseases	_____	_____	⊗ 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)
				⑧ M ⑧ F	⑧ Hispanic ⑧ Other			
				⑧ M ⑧ F	⑧ Hispanic ⑧ Other			
				⑧ M ⑧ F	⑧ Hispanic ⑧ Other			
				⑧ M ⑧ F	⑧ Hispanic ⑧ Other			
				⑧ M ⑧ F	⑧ Hispanic ⑧ Other			
				⑧ M ⑧ F	⑧ Hispanic ⑧ Other			
				⑧ M ⑧ F	⑧ Hispanic ⑧ Other			

***35. Did all of these children reside with you at your last permanent address?** ⑧ Yes ⑧ No

Do all of these children continue to live with you? ⑧ Yes ⑧ No

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

____

____

____

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

Source	Any income received in the past 30 days? (Y/N)	Amount	Source	Any income received in the past 30 days? (Y/N)	Amount
® 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)

Source	Any income received in the past 30 days? (Y/N)	Amount	Source	Any income received in the past 30 days? (Y/N)	Amount
® 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**