FAMILIES FIRST OF MONROE COUNTY

Intake Form

United Way Community Partner

www.familiesfirstofmonroecounty.org • Resources • Information • Referrals

APPLICANT NAME: (Last) ___________________________________ (First) ________________________________ (MI) _______

HOUSEHOLD SIZE: ________NUMBER OF ADULTS? _______ NUMBER OF CHILDREN? _______

CONTACT INFORMATION: Address:____

Phone #:______________________ Birthdate:____/____/_______ SS#:_______-____-_______

HAVE YOU RECEIVED HOUSING SERVICES FROM FAMILIES FIRST OF MONROE COUNTY BEFORE? ☐**YES** ☐**NO**

IF SO, WHEN? ___________________ WHAT HAPPENED/RESULT? ____

ARE YOU A SURVIVOR OF DOMESTIC VIOLENCE? ☐YES ☐NO HOW LONG AGO? _______________________________

ARE YOU CURRENTLY FLEEING ? ☐YES ☐NO

If you have ever served in the military, do you have a DD-214? ☐YES ☐NO Do you currently receive benefits/services? ☐YES ☐NO

Has any adult in the household ever had placement in a foster care system? ☐YES ☐NO Who?_______________________________

If yes, which state(s)? ____________ Age person left the foster care system? _______

Has anyone in the household gone by another name? ☐ Yes ☐ No If yes, Name: ___________________

PLEASE INDICATE THE HIGHEST - GRADE LEVEL ACHIEVED

☐ Some High School ☐ High School Diploma ☐ Some College ☐ Technical Degree

☐ College Degree 2 year ☐ College Degree 4 year ☐ Post Graduate Degree ☐ Other

DOES ANYONE IN YOUR HOUSEHOLD HAVE A DISABLING CONDITION OF LONG DURATION? ☐YES ☐NO

NAME OF PERSON: __________________ WHAT CONDITION(S)? *(See List Below):* _______________________________

DIAGNOSED BY DOCTOR/THERAPIST/AODA COUNSELOR? ☐YES ☐NO CURRENTLY RECEIVING TREATMENT/SERVICES? ☐YES ☐NO

SSA DETERMINED? ☐YES ☐NO IF NO, APPLICATION PENDING? ☐YES ☐NO DATE FILED: _____________

NAME OF PERSON: __________________ WHAT CONDITION(S)? *(See List Below):* _______________________________

DIAGNOSED BY DOCTOR/THERAPIST/AODA COUNSELOR? ☐YES ☐NO CURRENTLY RECEIVING TREATMENT/SERVICES? ☐YES ☐NO

SSA DETERMINED? ☐YES ☐NO IF NO, APPLICATION PENDING? ☐YES ☐NO DATE FILED: _____________

NAME OF PERSON: __________________ WHAT CONDITION(S)? *(See List Below):* _______________________________

DIAGNOSED BY DOCTOR/THERAPIST/AODA COUNSELOR? ☐YES ☐NO CURRENTLY RECEIVING TREATMENT/SERVICES? ☐YES ☐NO

SSA DETERMINED? ☐YES ☐NO IF NO, APPLICATION PENDING? ☐YES ☐NO DATE FILED: _____________

List of Disabling Conditions

Alcohol abuse | Chronic Health Condition | Developmental | Drug abuse | HIV/AIDS

Mental health condition | Physical (includes mobility) | Other

IS ANYONE IN THE HOUSEHOLD ON PROBATION? ☐**YES** ☐**NO** **PAROLE?** ☐**YES** ☐**NO**

Name of person(s)____

Parole/Probation Agent Name: ____

INCOME SOURCE

Source of Income Key: Alimony Child Support Earned Income General Assistance Pension Private Disability Ins.
Retirement (SS) SSDI SSI W2 Worker's Comp Unemployment Veteran Disability Payment Veteran Pension

Household Member	Source of Income	Start Date	Hourly Amount	Hrs/per week	Monthly Gross	Yearly Gross
	Income Source					
	Income Source					
	Income Source					
	Income Source					

TOTAL ANNUAL HOUSEHOLD INCOME: $_____

HOUSEHOLD COMPOSITION

□Single □Female Single Parent □Male Single Parent □Married Couple & Child(ren) □Unmarried Couple (parent & partner) & Child(ren)
□Extended Family □Married Couple w/o Children □Unmarried Couple w/o Children □Related caregiver (Custody) □Related Caregiver (w/o Custody)
□Unrelated caregiver (custody) □Unrelated caregiver (non-custody) □Other_____

First **Name**	**MI**	**Last Name**	**SSN #**	**Relationship to HH**	**Gender**	**Date of Birth**	**Age**	**Veteran Y/N**	**Race(s)**	**Hispanic Y/N**	**Student Y/N**
				Head of Household	Gender				Race		
					Gender				Race		
					Gender				Race		
					Gender				Race		
					Gender				Race		
					Gender				Race		

RACE CODES: **A-**Asian **AI-**American Indian/Alaska Native **B**-Black/African American **NH**-Native Hawaiian/Pacific Islander **W**-White

PLEASE CHECK ALL NON-CASH BENEFITS RECEIVED BY ANY MEMBER OF THE HOUSEHOLD

□VA Medical
□Private pay health Ins
□Child care assistance
□Section 8/Public Housing
□Medicare
□COBRA
□Temp. rental assistance
□Food Share (SNAP) Amount _____
□Medicaid
□State insurance for Adults
□Transportation assistance
□Other _____
□Badger Care (SCHIP)
□Employer provided health ins
□WIC
□Household does not receive any Non-Cash Benifits

LIVING SITUATION LAST NIGHT:

□ **EMERGENCY SHELTER, INCLUDING HOTEL OR MOTEL PAID FOR WITH EMERGENCY SHELTER VOUCHER**

□ **PLACE NOT MEANT FOR HABITATION INCLUSIVE OF "NON-HOUSING SERVICE SITE (OUTREACH PROGRAMS ONLY)"**

□ **SAFE HAVEN**

IF ANY OF THE ABOVE 3 ARE CHECKED, APPROXIMATE DATE STARTED _____REQUIRED FOR HOUSING**

□ **HOTEL OR MOTEL PAID FOR WITHOUT EMERGENCY SHELTER VOUCHER**
□ **STAYING OR LIVING IN A FRIEND'S ROOM, APARTMENT OR HOUSE**
□ **RENTAL BY CLIENT, NO HOUSING SUBSIDY**
□ **RENTAL BY CLIENT, WITH VASH HOUSING SUBSIDY**
□ **RENTAL BY CLIENT, WITH OTHER HOUSING SUBSIDY (INCL. RRH)**
□ **JAIL, PRISON, OR JUVENILE DETENTION FACILITY**
□ **TRANSITIONAL HOUSING FOR HOMELESS PERSONS (INCL. HOMELESS YOUTH)**
□ **PERMANENT HOUSING (OTHER THAN RRH) FOR FORMERLY HOMELESS PERSONS**
□ **PSYCHIATRIC HOSPITAL OR OTHER PSYCHIATRIC FACILITY CENTER**
□ **SUBSTANCE ABUSE TREATMENT FACILITY OR DETOX**
□ **STAYING OR LIVING IN A FAMILY MEMBER'S ROOM, APARTMENT OR HOUSE**
□ **OTHER _____**
□ **RESIDENTIAL PROJECT OR HALFWAY HOUSE WITH NO HOMELESS CRITERIA**
□ **LONG-TERM CARE FACILITY OR NURSING HOME**
□ **RENTAL BY CLIENT WITH GPD OR TIP SUBSIDY**
□ **FOSTER CARE HOME OR FOSTER CARE GROUP HOME**
□ **HOSPITAL (NON-PSYCHIATRIC)**
□ **OWNED BY CLIENT, NO HOUSING SUBSIDY**
□ **OWNED BY CLIENT, WITH HOUSING SUBSIDY**

LENGTH OF LIVING SITUATION IN PLACE MARKED ABOVE

□ One night or less
□ 2-6 nights
□ One week or more, but less than one month
□ One to three months
□ More than three months, but less than one year
□ One year or longer

ESTIMATE HOW MUCH LONGER YOU EXPECT TO RESIDE THERE

□ Can't go back
□ Less than 3 months
□ 3 months to a year
□ More than a year
□ Until shelter/housing is received

Number of times you have been on the Street, in an Emergency Shelter, on a motel voucher, or in a Safe Haven in the past three years including today: ____ times

Number of months homeless on the Street, in an Emergency Shelter, on a motel voucher, or in a Safe Haven in the past three years:

□ 0-12 months (if 0-12, list number of months _____)
□ More than 12 months

CAUSE OF HOMELESSNESS (CHECK ALL THAT APPLY)

□ Divorce/Separation
□ Loss of job
□ Parole
□ Low income
□ Ran Away
□ Domestic Violence
□ Eviction
□ Mental illness
□ Rent increase
□ Thrown out
□ Substance abuse
□ Other_____

NO INCOME – Do you certify that you do not have any income from any source at this time?

□ YES □NO □ VERBAL

Do you give consent that this agency may share information with other agencies such as, but not limited to, your situation, household demographics, and any questions asked during this assessment for the purpose of providing a referral to Coordinated Entry Prioritization Lists?

□ YES □NO □ VERBAL

ACKNOWLEDGEMENT

I understand that the information contained in this application is provided voluntarily. The information is true and correct to the best of my knowledge. I am aware that providing false information or not reporting pertinent information is fraud. I also agree to notify the agency of any changes in income, family/household size, or address within 24 hours of such change. If I provide any false information, I understand that services may be denied. I understand that completion of this application does not guarantee that I will receive assistance.

□ **VERBAL**

_____ _____
Applicant Signature Date

_____ _____
Agency Rep Signature Date