

CoC Universal Intake Form

Name: (legal name only, please)	First	MI	Last
Social Security Number:	Maiden Name:	List any other name(s) used:	

Household Relationship Information

Household type (*Check one*):

<input type="checkbox"/> Couple with No Children	<input type="checkbox"/> Grandparent(s) & Child	<input type="checkbox"/> Single Female Parent	<input type="checkbox"/> Two Parent Family
<input type="checkbox"/> Couple (Parent & Friend) with Child(ren)	<input type="checkbox"/> Non-Custodial Caregivers	<input type="checkbox"/> Single Male Parent	
<input type="checkbox"/> Foster Parent	<input type="checkbox"/> Other	<input type="checkbox"/> Single Person	

Head of household? Yes No

Relationship to head of household (*Check one*): **Self (head of household only)**

Part 1

Housing Status? Literally Homeless
 Housed and at imminent risk of losing housing
 Housed and at-risk of losing housing
 Stably Housed Don't Know Refused

Type of Living Situation (Residence prior to program entry):

<input type="checkbox"/> Emergency Shelter (including Hotel or motel paid w/ emergency shelter voucher)	<input type="checkbox"/> Foster care home or foster care group home
<input type="checkbox"/> Permanent housing for formerly homeless persons (such as SHP, S + C, or SRO Mod Rehab)	<input type="checkbox"/> Owned by client, with housing subsidy
<input type="checkbox"/> Transitional housing for homeless (including homeless youth)	<input type="checkbox"/> Staying or living in a friend's room, apartment or house
<input type="checkbox"/> Owned by client, no housing subsidy	<input type="checkbox"/> Substance Abuse Treatment/Detox Center
<input type="checkbox"/> Staying/living in family member's room, apartment or house	<input type="checkbox"/> Jail/Prison/Juvenile Detention Facility
<input type="checkbox"/> Psychiatric hospital or facility	<input type="checkbox"/> Rental by client VASH Subsidy
<input type="checkbox"/> Hospital (non-psychiatric)	<input type="checkbox"/> Rental by client w/ other non-VASH Housing subsidy
<input type="checkbox"/> Rental by client no housing subsidy	<input type="checkbox"/> Hotel or motel paid without emergency shelter voucher
<input type="checkbox"/> Rental by client w/ other non-VASH Housing subsidy	<input type="checkbox"/> Place not meant for habitation (vehicle, abandoned building, bus/train/subway/airport, outside); inclusive of "non-housing service site (outreach programs only)"
<input type="checkbox"/> Other	<input type="checkbox"/> Safe Haven <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused

Length of Stay (How long have you been staying in this Type of Living Situation?):

<input type="checkbox"/> One week or less (less than 7 days)	<input type="checkbox"/> More than one week, but less than one month (8 to 30 days)
<input type="checkbox"/> One to three months (30 to 90 days)	<input type="checkbox"/> More than three months, but less than one year (90 days but less than 12 months)
<input type="checkbox"/> One year or longer (more than 12 months)	<input type="checkbox"/> Don't Know <input type="checkbox"/> Refused

Zip Code of Last Permanent Address: _____

Part 2 Client Information

Date of Birth: (mm/dd/yyyy): _____ / _____ / _____ (year is required)

Gender:

Female Male Transgender – Male to Female Transgender – Female to Male Other Don't Know
 Refused

Primary race:

<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> White	<input type="checkbox"/> Don't Know		<input type="checkbox"/> Refused

Secondary race (optional):

<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> White	<input type="checkbox"/> Don't Know		<input type="checkbox"/> Refused

Ethnicity: Hispanic/Latino Other (Non-Hispanic/Latino) Don't Know Refused

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Part 2 Client Information (cont'd)

Are you a U.S. military veteran who served in active duty? Yes No Don't Know Refused

Do you have a disabling condition? Yes No Don't Know Refused

Medical Insurance Status:

- | | | |
|---|---|--|
| <input type="checkbox"/> None (Self Pay) | <input type="checkbox"/> Kid's Connection | <input type="checkbox"/> Medicaid |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> VA Benefits | <input type="checkbox"/> Medicare & Medicaid |
| <input type="checkbox"/> Private Insurance | <input type="checkbox"/> Private & Medicaid | <input type="checkbox"/> Native American Health |
| <input type="checkbox"/> General Assistance | <input type="checkbox"/> Medicaid Share of Cost | <input type="checkbox"/> Private Ins. w/ Family Planning |
| <input type="checkbox"/> Every Woman Matters | <input type="checkbox"/> Underinsured – Hospital Only | <input type="checkbox"/> Underinsured – Deduct >\$1,000 |
| <input type="checkbox"/> Underinsured – Deduct >\$2,500 | <input type="checkbox"/> Underinsured – Deduct >\$5,000 | |

Part 3 Client Information

Last 30 day Income/Source of Income:

\$_____ Alimony	\$_____ Pension	\$_____ TANF
\$_____ Child Support	\$_____ Private Disability	\$_____ Unemployment
\$_____ Contributions from others	\$_____ Self-employed	\$_____ Veteran's Disability
\$_____ Earned Income	\$_____ SSA	\$_____ Veteran's Pension
\$_____ General Assistance	\$_____ SSI	\$_____ Workers Compensation
\$_____ Other	\$_____ SSDI	

Total Monthly Income: \$_____ No Financial Resources

Non-Cash Benefits (not all Non-Cash Benefits will have a dollar amount check if the benefit is received)

\$_____ Supplemental Nutrition Assistance Program (Food Stamps)	\$_____ TANF Child Care Services
\$_____ Medicaid	\$_____ TANF Transportation services
\$_____ Medicare	\$_____ Other TANF funded services
\$_____ Section 8, public housing, rental assistance	\$_____ Veteran's Medical Services (VA)
\$_____ State Children's Health Ins. (Kids Connection)	\$_____ Women, Infants, Children (WIC)
	\$_____ Other Non-Cash Benefits

Client's Residence Information

Street Address _____ Apt # _____ City _____ State _____ Zip Code _____
 County of Current Residence: _____ County of Legal Residence: _____

Home Phone	Cell Phone	Work Phone

Mailing Address if different than above: _____
 PO Box _____ City _____ State _____ Zip Code _____

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CoC Universal Intake Form

Other Members in Household

Name (legal name only, please):

First MI Last

SSN: _____

HOUSEHOLD INFORMATION:

Relationship to Head of Household (check one):

- Self (head of household only)**
- Daughter Grandmother Significant Other Wife
 Father Grandson Son
 Granddaughter Husband Step-daughter
 Grandfather Mother Step-son
 Other non-relative: _____
 Other relative: _____

Date of Birth: ____/____/____ (year is required)

Gender:

- Female Male
 Transgender – Male to Female Transgender – Female to Male
 Don't Know Other Refused

Race (enter 1 for primary and 2 for secondary, if applicable):

- American Indian/Alaskan Native
 White
 Asia
 Black
 Native Hawaiian/Pacific Islander
 Don't Know Refused

Ethnicity:

- Hispanic/Latino Other (Non-Hispanic/Latino)
 Don't Know Refused

Are you a U.S. military veteran who served in active duty?

- Yes No Don't Know Refused

Do you have a disabling condition?

- Yes No Don't Know Refused

Medical Insurance Status:

- | | |
|--|---|
| <input type="checkbox"/> None (Self Pay) | <input type="checkbox"/> Kid's Connection |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Medicare |
| <input type="checkbox"/> VA Benefits | <input type="checkbox"/> Medicare & Medicaid |
| <input type="checkbox"/> Private Insurance | <input type="checkbox"/> Private & Medicaid |
| <input type="checkbox"/> Native American Health | <input type="checkbox"/> General Assistance |
| <input type="checkbox"/> Medicaid Share of Cost | <input type="checkbox"/> Private w/ Family Planning |
| <input type="checkbox"/> Every Woman Matters | <input type="checkbox"/> Underinsured – Hospital Only |
| <input type="checkbox"/> Underinsured Deduct \$1000 | <input type="checkbox"/> Underinsured Deduct \$2,500 |
| <input type="checkbox"/> Underinsured Deduct \$5,000 | |

Last 30 day Income/Source of Income:

- | | |
|------------------------------------|-------------------------------|
| \$ _____ SSA | |
| \$ _____ SSI | |
| \$ _____ Alimony | \$ _____ SSDI |
| \$ _____ Child Support | \$ _____ TANF |
| \$ _____ Contributions from others | \$ _____ Unemployment |
| \$ _____ Earned Income | \$ _____ Veteran's Disability |
| \$ _____ General Assistance | \$ _____ Veteran's Pension |
| \$ _____ Other | \$ _____ Workers Compensation |
| \$ _____ Pension | |
| \$ _____ Private Disability | |
| \$ _____ Self-employed | |
- Total Monthly Income:**
 \$ _____
 No Financial Resources

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First MI Last

SSN: _____

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- Total Monthly Income:**
 \$ _____
 No Financial Resources