

HPRP Intake Form

GENERAL CLIENT INFORMATION

Agreed to ROI Yes No

HMIS Client ID # _____

Applicant 1 Full Legal Name

Date of Application

Applicant 2 Full Legal Name

Social Security Number

Age

Date of Birth

Social Security Number

Age

Date of Birth

Does Applicant have a phone? Yes No

Applicant Phone Number

Alternate Contact Name

Alternate Contact Phone Number

Race: (optional - check all that apply)
A1 A2
 Asian
 American Indian or Alaska Native
 Black or African American
 White
 Native Hawaiian/Other Pacific Islander

Ethnicity: (optional - check one)
A1 A2
 Hispanic
 Non-Hispanic/Other

Gender:

A1 A2
 Male
 Female

Marital Status:

A1 A2
 Married
 Single

Are you a Domestic Violence Victim?

A1 Yes No
A2 Yes No

If yes, how recent was the Domestic Violence?

A1 A2
 Within the past 3 months
 3 to 6 months ago
 6 to 12 months ago
 More than a year ago

Did you age out of foster care in Summit County?

A1 Yes No
A2 Yes No

Are you a U.S. Military Veteran?

A1 Yes No
A2 Yes No

Are you currently pregnant?

A1 Yes No
A2 Yes No

If yes, when are you due? _____

Do you have a long-term disability? Yes* No

Please check Disabilities that apply to you: A1 A2

(please check all that apply)

A1 A2
 Physical Disability
 Developmental Disability
 Chronic Health Condition

HIV/AIDS
 Mental Health
 Substance Abuse _____

FAMILY STATUS

Household Type (skip if single adult):

- | | | |
|---------------------------------------------------|------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Female Single Parent | <input type="checkbox"/> Two Parent Family | <input type="checkbox"/> Foster Parents |
| <input type="checkbox"/> Male Single Parent | <input type="checkbox"/> Couple w. no Children | <input type="checkbox"/> Grandparent and child |
| <input type="checkbox"/> Non-custodial care giver | <input type="checkbox"/> Other | |

How many children do you have? _____

HOUSING STATUS

What is your living situation?			
A1 A2		A1 A2	
<input type="checkbox"/> <input type="checkbox"/> Emergency Shelter*	<input type="checkbox"/> <input type="checkbox"/> Transitional housing for homeless	<input type="checkbox"/> <input type="checkbox"/> Permanent housing for homeless	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Hospital or Facility*
<input type="checkbox"/> <input type="checkbox"/> Hospital(non-psychiatric)*	<input type="checkbox"/> <input type="checkbox"/> Substance Abuse Facility*	<input type="checkbox"/> <input type="checkbox"/> Jail, Prison or Juvenile Facility*	<input type="checkbox"/> <input type="checkbox"/> Hotel/Motel no emergency shelter subsidy
<input type="checkbox"/> <input type="checkbox"/> Foster care/group home	<input type="checkbox"/> <input type="checkbox"/> Place not meant for habitation	<input type="checkbox"/> <input type="checkbox"/> Safe Haven	<input type="checkbox"/> <input type="checkbox"/> Staying/Living with Family
	<input type="checkbox"/> <input type="checkbox"/> Staying/Living with Friends	<input type="checkbox"/> <input type="checkbox"/> Rental by Client-No Subsidy	<input type="checkbox"/> <input type="checkbox"/> Rental by Client-VASH
	<input type="checkbox"/> <input type="checkbox"/> Rental by Client-Other Subsidy	<input type="checkbox"/> <input type="checkbox"/> Owned by Client-No Subsidy	<input type="checkbox"/> <input type="checkbox"/> Owned by Client-With Subsidy
	<input type="checkbox"/> <input type="checkbox"/> Other (please specify): _____		
A1 <input type="checkbox"/> Yes <input type="checkbox"/> No Client is homeless?		Extent of Homelessness?	
A2 <input type="checkbox"/> Yes <input type="checkbox"/> No Client is homeless?		A1 A2	
		<input type="checkbox"/> <input type="checkbox"/> First time homeless	
		<input type="checkbox"/> <input type="checkbox"/> 1 – 3 times in the past	
		<input type="checkbox"/> <input type="checkbox"/> Chronic: 4 times in the past 3 years	
		<input type="checkbox"/> <input type="checkbox"/> Long term: 2 years or more	
Housing Status: (check one):			
A1 A2			
1. <input type="checkbox"/> <input type="checkbox"/> Literally Homeless (Places not meant for human habitation, shelter, transitional housing, exiting institution following homelessness or survivor of domestic violence)			
2. <input type="checkbox"/> <input type="checkbox"/> Imminently losing their housing (Being evicted, discharged from hospital/institution with no place to go, condemned housing, etc with no subsequent housing and inadequate resources).			
3. <input type="checkbox"/> <input type="checkbox"/> Unstably housed and at risk of losing housing (At-risk due to high housing costs, conflict, or other conditions that put housing at risk and inadequate resources. Danger is not immediate)			
4. <input type="checkbox"/> <input type="checkbox"/> Stably housed (Not at risk of losing housing)			
5. <input type="checkbox"/> <input type="checkbox"/> Don't Know			
6. <input type="checkbox"/> <input type="checkbox"/> Refused			
How long have you been in your current living situation?			
A1 A2		A1 A2	
<input type="checkbox"/> <input type="checkbox"/> 1 week or less	<input type="checkbox"/> <input type="checkbox"/> 1 to 3 months	<input type="checkbox"/> <input type="checkbox"/> 1 year or longer	<input type="checkbox"/> <input type="checkbox"/> More than 1 week but less than 1 month
			<input type="checkbox"/> <input type="checkbox"/> More than 3 months but less than 1 year
Client's Present/Last Address*		City	State
			Zip

* Unless a client of CSB, must be in Summit County

ASSISTANCE REQUESTED

Assistance Type:	
<input type="checkbox"/> Rent Assistance:	<input type="checkbox"/> Utility Bill Assistance:
<input type="checkbox"/> Security Deposit Assistance:	<input type="checkbox"/> Utility Deposit Assistance:
<input type="checkbox"/> Moving Expense Assistance:	

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INCOME

What income do you currently receive? (please check all that apply and fill in all dollar amounts)

Proof of Income? Yes No

Attach verification of all income listed.

Source and Amount of Income:	Applicant 1	Applicant 2	Start Date
<input type="checkbox"/> Earned Income			
<input type="checkbox"/> Unemployment Insurance			
<input type="checkbox"/> Supplemental Security Income (SSI)			
<input type="checkbox"/> Social Security Disability (SSDI)			
<input type="checkbox"/> Veterans Disability Income			
<input type="checkbox"/> Private Disability Insurance			
<input type="checkbox"/> Workers Compensation			
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)			
<input type="checkbox"/> General Assistance			
<input type="checkbox"/> Retirement Income from Social Security			
<input type="checkbox"/> Veteran's Pension			
<input type="checkbox"/> Pension from a former job			
<input type="checkbox"/> Child Support			
<input type="checkbox"/> Alimony or other Spousal Support			
<input type="checkbox"/> Other Source:			
Source of Non-Cash Benefit			
<input type="checkbox"/> Food Stamps (SNAP)			
<input type="checkbox"/> Medicaid			
<input type="checkbox"/> Medicare			
<input type="checkbox"/> State Children's Health Insurance Program (SCHIP)			
<input type="checkbox"/> WIC – Special Supplemental Nutrition Program			
<input type="checkbox"/> Veteran's Administration (VA) Medical Services			
<input type="checkbox"/> TANF Child Care			
<input type="checkbox"/> TANF Transportation			
<input type="checkbox"/> Other TANF Funded Services:			
<input type="checkbox"/> Section 8, Public Housing or Other Rental Assistance			
<input type="checkbox"/> Temporary Rental Assistance			
<input type="checkbox"/> Other:			

EMPLOYMENT STATUS

Are you currently employed?

A1 A2

Yes, I am working.

How many hours did you work last week? _____

No, I am unemployed.

Are you looking for work? A1 Yes No, explain why you are unemployed or not looking for work:

A2 Yes No, explain why you are unemployed or not looking for work:

<p>What is your current job status? (check one)</p> <p>A1 <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Seasonal</p> <p>A2 <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Seasonal</p>

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EDUCATION

Are you currently in school or working on a Degree? A1 Yes No A2 Yes No

If yes, name of school: _____

Have you received Vocational Training? A1 Yes No A2 Yes No

What is the highest level of Education you have completed:

- | | | |
|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| A1 A2 | A1 A2 | A1 A2 |
| <input type="checkbox"/> <input type="checkbox"/> No schooling completed | <input type="checkbox"/> <input type="checkbox"/> 9 th grade | <input type="checkbox"/> <input type="checkbox"/> High School Diploma |
| <input type="checkbox"/> <input type="checkbox"/> Nursery school to 4 th grade | <input type="checkbox"/> <input type="checkbox"/> 10 th grade | <input type="checkbox"/> <input type="checkbox"/> GED |
| <input type="checkbox"/> <input type="checkbox"/> 5 th or 6 th grade | <input type="checkbox"/> <input type="checkbox"/> 11 th grade | <input type="checkbox"/> <input type="checkbox"/> Post-Secondary School |
| <input type="checkbox"/> <input type="checkbox"/> 7 th or 8 th grade | <input type="checkbox"/> <input type="checkbox"/> 12 th grade, no diploma | |

Name degrees have you earned? _____

CHILDREN INFORMATION

Child Name _____	Child Race: (check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
Child SSN _____	Long-term disability? <input type="checkbox"/> Yes* <input type="checkbox"/> No Type of Disability: _____
Child Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Child Ethnicity: (check one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Don't Know <input type="checkbox"/> Non-Hispanic/Other <input type="checkbox"/> Refused
Child DOB _____ Age _____	
In School? <input type="checkbox"/> Yes <input type="checkbox"/> No Name/Type of school: _____	
Enrollment problems: _____	
Permanent Custody: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child Name _____	Child Race: (check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
Child SSN _____	Long-term disability? <input type="checkbox"/> Yes* <input type="checkbox"/> No Type of Disability: _____
Child Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Child Ethnicity: (check one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Don't Know <input type="checkbox"/> Non-Hispanic/Other <input type="checkbox"/> Refused
Child DOB _____ Age _____	
In School? <input type="checkbox"/> Yes <input type="checkbox"/> No Name/Type of school: _____	
Enrollment problems: _____	
Permanent Custody: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child Name _____	Child Race: (check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
Child SSN _____	Long-term disability? <input type="checkbox"/> Yes* <input type="checkbox"/> No Type of Disability: _____
Child Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Child Ethnicity: (check one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Don't Know <input type="checkbox"/> Non-Hispanic/Other <input type="checkbox"/> Refused
Child DOB _____ Age _____	
In School? <input type="checkbox"/> Yes <input type="checkbox"/> No Name/Type of school: _____	
Enrollment problems: _____	
Permanent Custody: <input type="checkbox"/> Yes <input type="checkbox"/> No	

PROGRAM EXIT INFORMATION

Client's Exit date:

Reason Client left program:

- Left for housing opportunity before completing program
- Completed Program
- Non-payment of rent/occupancy charge
- Criminal activity/violence/property destruction
- Disagreement with rules/person
- Unknown/disappeared
- Other (please specify): _____
- Reached maximum program time
- Non-compliance with program
- Needs could not be met
- Death
- AWOL

Client's Destination:

- Permanent housing for formerly homeless (S+C, SHP, etc.)
- Own house/Apartment
- Hotel/motel w/out Emergency Shelter
- Hospital (non-psychiatric)
- Transitional housing for homeless
- Foster care/Foster care group home
- Places not meant for habitation/street
- Staying in a family members room/apt.
- Don't know
- Other: _____
- Rental room/house/apartment
- Emergency Shelter room/house/apartment
- Psychiatric hospital/facility
- Jail, Prison/juvenile detention
- Reunification with Family home
- Substance abuse treatment/detox center
- Staying in a friend's room/house/apt.
- Refused

Client's Destination Tenure:

- Permanent
- Transitional
- Don't Know
- Refused

Was the client employed at exit date? Yes No
If yes, what was the employment status? (check one) Permanent Temporary Seasonal

***Be sure to update income area if client was employed at exit date.**