First Impression SC's Transition Place for Single Women Intake Form

Program Entry Date _____/_____/20_____ **Referred by:** _____ **SSN:** _____/_____/_____

Last Name: _____ **First:**_____ **Middle Name:**_____

Current Address:_____ **City:** _____ **State:**____**Zip:**_____

 # Weeks/Months at temp Address: _____ **is applicant pregnant** ☐ yes ☐ no #Months pregnant _____

Date of Birth: _____ **Disabled:** ☐ yes ☐ no **Domestic Violence** ☐ yes ☐ no

Phone #: _____****List medical Problem(s) from pg. 2:** _____

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Widowed
- ☐ Divorced

Education:
- ☐ 0-8 years
- ☐ 9-12(non-HS grad)
- ☐ HS Grad/GED
- ☐ 12+
- ☐ College Grad
- ☐ Junior College
- ☐ College (non-grad)
- ☐ Voc/Tech (completed)
- ☐ Graduate Degree

Ethnicity:
☐ Hispanic/ Latino Origin

Race:
- ☐ African American/Black
- ☐ Caucasian
- ☐ Native Hawaiian/ Pacific Islndr.
- ☐ Asian
- ☐ American Indian/AK Native
- ☐ African American & White
- ☐ American Indian/AK/White
- ☐ Asian & White
- ☐ American Indian/AK/Black
- ☐ Other Multi Racial

# of Persons in the household (include Head of Household) _____

Last Permanent Address: (Last Place resided for 90 days or more)

Street Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Last Perm. Phone: _____ **Food Stamps**: ☐ yes ☐ no **$**_____

 # weeks/months at last permanent address: _____

Monthly Income & Amounts:
Child Support:_____
TANF: _____
Employment FT:_____
Employment PT:_____
Pension:_____
Veterans Ben:_____
SSA:_____
SSDI:_____
SSI:_____
Unemployment:_____
Other:_____

Total: $_____

Total Monthly Family Income: $_____

Family Type:
- ☐ Single Female
- ☐ Single Male
- ☐ Female w/ children
- ☐ Male w/ children
- ☐ Couple no children
- ☐ Couple w/children
- ☐ Extended family

Insurance Type:
- ☐ Medicare
- ☐ Medicaid
- ☐ Private
  - ☐ None
- ☐ VA Medical

Veteran: ☐ yes ☐ no ☐ don't know ☐ refused

Housing Status & Cost of Housing
- ☐ Homeless-
  Homeless length_____
- ☐ Rent $_____
- ☐ Own $_____

***List the number of homeless shelters you have stayed at in the prior 6 months?** _____

***List the number of homeless episodes you have experienced within the last 3 years** _____

Where did you stay last night?
- ☐ On the street
- ☐ Emergency Shelter
- ☐ Transitional Housing
- ☐ Psychiatric Facility
- ☐ Substance Abuse/Detox Facility
- ☐ Hospital (non-psychiatric)
- ☐ jail/prison/juvenile facility
- ☐ Domestic Violence Situation
- ☐ Living w/relatives/friends
- ☐ Apartment/house you rent
- ☐ Apartment/house you own
- ☐ Staying/living with family
- ☐ Staying/living with friend
- ☐ Motel NOT paid by ES shelter voucher
- ☐ Foster care/group home
- ☐ Permanent Supportive Housing
- ☐ Place not meant for habitation (e.g., car/bus/train/subway/outside)
- ☐ Other

With regard to where you stayed last night, how long have you stayed/resided there?
- ☐ 1 week or less
- ☐ more than 1 week, less than 1 month
- ☐ 1-3 months
- ☐ 4-6 months
- ☐ 7-12 months
- ☐ 1-2 years
- ☐ 2-4 years
- ☐ 4 years or more

Date:_____

Reason for Homelessness/Emergency Assistance:
CHOOSE ONE!

☐ Stranded/Transient	☐ Insufficient Income	☐ Fire/disaster
☐ Drug/Alcohol Problem	☐ Eviction	☐ High Risk Neighborhood
☐ Loss of Public Assistance	☐ Alcohol Abuse	☐ Release from corrections facility
☐ Medical Condition	☐ Drug Abuse	☐ Mismanagement of income
☐ Substance Abuse	☐ Domestic Violence	☐ Release from Mental Health Facility
☐ Condemnation	☐ Other—Specify_____	

Medical Problems to choose from:

Drug Problem	Alcohol Problem	Physical Health	Mental Health	ADHD
Physical Handicap	HIV/AIDS infected	Domestic Violence	Dual Diag. SA MI	Other-Specify:
Dual Diag. MI DD	Dual Diag. AA MI	Develop Disability	Learning Disability	_____

Emergency Contacts:

Primary Contact:

Relationship:_____ Name:_____

Address:_____ City:_____ State: _____ Zip:_____

Phone Number: _____

Secondary Contact:

Relationship:_____ Name:_____

Address:_____ City:_____ State: _____ Zip:_____

Phone Number: _____

Application Affirmation & Authorization to Verify Information

APPLICATION STATEMENT: I certify that the above information is an accurate and complete disclosure of the requested information. I hereby acknowledge that the information relating to determination of my eligibility requires verification and/or documentation, and by my signature, I authorize the release of such information as may be required for the determination of my eligibility.

Signature of Applicant _____ Date:_____

Intake Worker Signature _____Date:_____

Date:_____

NOTES: