THE RELIGIOUS COALITION
For Emergency Human Needs

| Universal Intake Form | |
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| Office Use Only - Do Not Fill Out This Section | |
| Today's Date: | Interviewed By: |
| Entered into HMIS on: | By: |
| HMIS (Service Point) Number: | |
| Frederick County Resident: □ Yes | □ No |

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| Legal Name: | Last Name: |
| | First Name: |
| | Middle Name |
| | Suffix: |
| | Alias or Maiden Name: |

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|---|---|---|---|
| Social Security Number: | - - | □ Don't Know / Don't Have SS# | □ Refused |

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|---|---|---|---|---|
| U.S. Military Veteran? | □ Yes | □ No | □ Don't Know | □ Refused |

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|---|---|---|---|---|
| Date of Birth: | / / | Age: _____ | □ Don't Know | □ Refused |

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| Current Address: | Street Address: | | | |
| | City: | State: | County: | Zip Code: |

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| Phone Number: | Home Phone: |
| | Work Phone: |
| | Cell Phone: |

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| E-Mail Address: | |

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| Primary Race (Check All That Apply): | □ American Indian/Alaska Native □ Asian □ Black/African American<br>□ Native Hawaiian/Other Pacific Islander □ White □ Refused |

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| Ethnicity (Check Only One): | □ Non-Hispanic/Non-Latino □ Hispanic/Latino □ Don't Know □ Refused |

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| Gender: | □ Male | □ Female | □ Transgender Male to Female | □ Transgender Female to Male | □ Refused |

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| Family Type (Check Only One): | □ Single Adult □ Single Female Parent □ Single Male Parent<br>□ Two Parent Household □ Two Adults – No Children □ Other_____ |
| Family Size: | □ One □ Two □Three □ Four □ Five □ Six □Seven □ Eight or More □ Refused |

Revised 9/07/2017

| Family Make – Up: | Number of Adults _____ | Number of Children _____ |
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| Do You Have a Disabling Condition? | □ Yes | □ No | □ Don't Know | □ Refused |
|---|---|---|---|---|

| Monthly Income Information ( How Much Have **YOU** Earned in the Last 30 Days) | | | |
|---|---|---|---|
| Alimony other Spousal Support | $ | Rental Income | $ |
| Annuities | $ | Retirement Disability | $ |
| Bank Interest | $ | Retirement from Social Security | $ |
| Child Support | $ | Self-Employment Wages | $ |
| Contributions from Other People | $ | SSDI | $ |
| Dividends (Investments) | $ | SSI | $ |
| **Earned Income** | $ | State Disability | $ |
| General Assistance | $ | TANF | $ |
| GPA | $ | Unemployment Insurance | $ |
| MCHIP | $ | VA Non-Service Connected Disability Pension | $ |
| Medical Assistance | $ | VA Service Connected Disability Pension | $ |
| No Financial Assistance | $ | Workers Compensation | $ |
| Pension or Retirement Income | $ | Other | $ |
| POC Voucher | $ | Other | $ |
| Private Disability Insurance | $ | ***Total Monthly Income*** | $ |
| Rail Road Retirement | $ | ***Total Monthly Household Income*** | $ |

| Expenses (How much are your bills a month) | | Debt (List Total Amount of Debt Owed) | |
|---|---|---|---|
| Rent/Mortgage | $ | Credit Cards | $ |
| Electric | $ | School Loans | $ |
| Gas / Kerosene / Oil | $ | Liens | $ |
| Food | $ | Garnishments | $ |
| Water / Sewer | $ | Mortgage | $ |
| Doctor | $ | Car Loan | $ |
| Prescriptions | $ | Medical Bills | $ |
| Child Support | $ | Child Support Arrears | $ |
| Gasoline | $ | Outstanding Bills | $ |
| Car Payment | $ | Other | $ |
| Car Insurance | $ | Other | $ |
| Cable / Internet / Phone | $ | Other | $ |
| Debt Repayment | $ | Other | $ |
| Other | $ | Other | $ |
| ***Total Monthly Expenses*** | $ | ***Total Debt Owed*** | $ |

| Education (Highest Level of School Completed): | □ No Schooling Completed □ Pre-School to 4th Grade □ 5th or 6th Grade □ 7th or 8th Grade □ 9th Grade □ 10th Grade □ 11th Grade □ 12th Grade –No Diploma □ 12th Grade – Diploma □ GED □ Post-Secondary □ Don't Know □ Refused |
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| Health Insurance: | □ None □ Private Pay Health Insurance □ Health Insurance Through COBRA □ Employer Provided Health Insurance □ VA Medical Services □ Medicare □ Maryland Children's Health Program (MCHIP) □ Medical Assistance (MA) |
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| Emergency Contact: | Name: |
| | Relationship: |
| | Contact Number: |


## DO NOT PROCEED!

**The following section is to be completed by STAFF/VOLUNTEER ONLY during interview with Client.**

Select "Homeless" if Client is literally homeless. I.E. Individuals and families who live in a place not meant for human habitation (including the streets or in their car), emergency shelter, transitional housing, and hotels paid for by a government or charitable organization.

Select "Imminent Risk of Homelessness" if Client will lose their primary nighttime residence within 14 days and has no other resources or support networks to obtain other permanent housing

Select "Homeless under other Federal Statues" if Client is an Unaccompanied youth under 25 years of age, or family with children and youth, who do not meet any of the other categories but are homeless under other federal statutes, have not had a lease and have moved 2 or more times in the past 60 days and are likely to remain unstable because of special needs or barriers.

Select Fleeing Domestic Violence if Client is fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking and who lack resources and support networks to obtain other permanent housing.

| Housing Status: | □ Homeless □ At Imminent Risk of Losing Housing □ At Risk of Homelessness<br>□ Homeless Only Under Other Federal Statues □ Fleeing Domestic Violence □ Stably Housed* | |
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| Do you RENT or OWN your Housing? | □ Rent | □ Own |

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| Where Did You Stay Last Night? (Check only One): | □ Emergency Shelter, Including Hotel/Motel Paid for with Emergency Shelter Voucher |
| | □ Foster Care Home or Foster Care Group Home |
| | □ Hospital or other Residential Non-Psychiatric Medical Facility |
| | □ Hotel or Motel Paid for Without Emergency Shelter Voucher (Self Paid) |
| | □ Jail, Prison, or Juvenile Detention Facility |
| **IF <u>CLIENT OWNS HOME,</u> PLEASE CHOOSE➔ ONE OF THESE TWO (2) ➔ OPTIONS** | □ Long-Term Care Facility or Nursing Home |
| | □ Owned by Client, No Ongoing Housing Subsidy |
| | □ Owned by Client, with Ongoing Housing Subsidy |
| | □ Permanent Housing for Formerly Homeless Persons |
| | □ Place Not Meant for Habitation (Outside, In a Car, In a tent, On a Bench etc.) |
| | □ Psychiatric Hospital or other Psychiatric Facility |
| **IF CLIENT <u>PAYS RENT,</u> ➔ PLEASE CHOOSE ONE ➔ OF THESE FOUR (4) ➔ OPTIONS** | □ Rental by Client, No Housing Assistance |
| | □ Rental by Client, with Veterans Administration Supportive Housing (**VASH**) |
| | □ Rental by Client, Grant and Per Diem(**GPD**) or Transition in Place(**TIP**) Program |
| | □ Rental by Client, with **Section 8, Public Housing, Shelter+Care, Housing First, RAP** |
| **IF CLIENT IS STAYING WITH A <u>FAMILY MEMBER</u> OR <u>FRIEND</u> PLEASE ➔ CHOOSE ONE OF THESE➔ TWO (2) OPTIONS** | □ Residential Project or Halfway House with No Homeless Criteria |
| | □ Safe Haven (Temporary Shelter for Battered Women and Children) |
| | □ Staying or Living in a Family Member's Room, Apartment or House |
| | □ Staying or Living in a Friend's Room, Apartment or House |
| | □ Substance Abuse Treatment Facility or Detox Center |
| | □ Transitional Housing for Homeless Persons (including homeless youth) |
| | □ Other:_____ |

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| How long have you lived or stayed at your current address? | □ 1 Day or Less □ 2 Days to 1 Week □ More Than 1 Week But Less Than 1 Month □ 1 to 3 Months □ More Than 3 Months but Less than 1 Year □ 1 Year or Longer |

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| Zip Code of Last Permanent Address: | |

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| **Where will you stay AFTER you receive assistance?** **(Check only One):** | □ Emergency Shelter, Including Hotel or Motel Paid for with Emergency Shelter Voucher |
| | □ Foster Care Home or Foster Care Group Home |
| | □ Hospital or other Residential Non-Psychiatric Medical Facility |
| | □ Hotel or Motel Paid for Without Emergency Shelter Voucher (Self Paid) |
| | □ Jail, Prison, or Juvenile Detention Facility |
| | □ Long-Term Care Facility or Nursing Home |
| **IF CLIENT OWNS <u>HOME</u>, ➔ PLEASE CHOOSE ONE OF ➔ THESE TWO (2) OPTIONS** | □ Owned by Client, No Ongoing Housing Subsidy |
| | □ Owned by Client, with Ongoing Housing Subsidy |
| | □ Permanent Housing for Formerly Homeless Persons |
| | □ Place Not Meant for Habitation (Outside, In a Car, In a tent, On a Bench etc.) |
| | □ Psychiatric Hospital or other Psychiatric Facility |
| | □ Rental by Client, No Housing Assistance |
| **IF CLIENT <u>PAYS RENT</u>, ➔ PLEASE CHOOSE ONE OF ➔ THESE FOUR (4) OPTIONS ➔** | □ Rental by Client, with Veterans Administration Supportive Housing (**VASH**) |
| | □ Rental by Client, Grant and Per Diem(**GPD**) or Transition in Place(**TIP**) Program |
| | □ Rental by Client, with **Section 8, Public Housing, Shelter+Care, Housing First, RAP** |
| | □ Residential Project or Halfway House with No Homeless Criteria |
| | □ Safe Haven(Temporary Shelter for Battered Women and Children) |
| **IF CLIENT IS STAYING WITH ➔ A <u>FAMILY MEMBER</u> OR ➔ <u>FRIEND,</u> PLEASE CHOOSE ONE OF THESE TWO (2) OPTIONS THEN SELECT TEMPORARY OR PERMANENT ARRANGEMENT** | □ Staying or Living in a Family Member's Room, Apartment or House |
| | □ Staying or Living in a Friend's Room, Apartment or House |
| | - **Family/Friend Arrangement is: □ Temporary □ Permanent** |
| | □ Substance Abuse Treatment Facility or Detox Center |
| | □ Transitional Housing for Homeless Persons (including homeless youth) |
| | □ Other:_____ |

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| Relationship to Head of Household? | □ Self (Head of Household) | □ Head of Household's Child |
| | □ Head of Household's Spouse or Partner | □ Head of Household's Other Relation |
| | □ Other – Non Relation to Head of Household | |

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| Client Signature | | Date: | |
| Witness (Staff) Signature: | | Date: | |