

INTAKE FORM

HMIS ID #:

1. INTAKE SUMMARY

Intake Date: _____ Staff Name: _____
Location/Office: _____ Client Authorization Signed: yes no

2. APPLICANT PROFILE – This is YOU as the head of household

Print all information clearly. If we can't read it, we can't help you.

First Name: _____ MI: _____ Last Name: _____ Suffix: _____

Address: _____

City: _____ Zip Code: _____

Phone: _____ Alternate Phone: _____
(Make sure we can reach you at one of these numbers! If we can't reach you no payments will be processed)

Social Security #: _____ - _____ - _____ Date of Birth: _____ Age: _____

- Citizen of the United States
- Non-citizen

Status: _____

Picture ID Type: _____ ID #: _____
(For example, is this a CA drivers license, military ID, etc.)

Gender

- Male
- Female
- Transgender
- Don't know
- Refused

Marital Status

- Single/never married
- Married living with spouse
- Married not living with spouse
- Divorced
- Widowed

Household Type

- Single adult no children
- Single parent female
- Single parent male
- Two parents with children
- Two adults no children

U.S. Military Veteran

- Yes
- No

Education

- Up to 8th grade
- 9th – 12th – non graduate
- High school grad or GED
- Some college
- 2 or 4 year college grad

Race Primary Secondary

- American Indian/Alaska Native
- Asian
- Black or African-American
- Native Hawaiian or Pacific Island
- White
- Other Multi-Racial
- Other
- Don't know

Ethnicity

- Non-Hispanic/Non-Latino
- Hispanic/Latino
- Don't know
- Refused

Insurance

- Medi-Cal
- Medi-Caid
- Medi-Care
- Private insurance
- Self-insured
- None
- Unknown
- HMO
- MIA (Medically Indigent Adult)

Housing Status

- Literally homeless
- Housed at imminent risk of losing housing
- Housed at risk of losing housing
- Stably housed

How Long at Current Address

- Less than one month
- One to three months
- Three to six months
- Six to twelve months
- One to two years
- Three to five years
- Six to eight years
- Nine years or more

Residence Prior to Program Entry

- Rental by client
- Transitional housing for homeless persons
- Domestic violence

Length of Stay in Previous Place

- One week or less
- More than one week, less than one month
- One to three months
- More than three months, less than one year

3. HMIS QUESTIONS**Are You Currently Homeless?**

- No
- Yes
- Don't know
- Refused

Do You Have a Physical Disability?

- No
- Yes
- Don't know
- Refused

Do You Have a Developmental Disability?

- No
- Yes
- Don't know
- Refused

Do You Have Any Other Special Needs?

- No
- Yes
- Don't know
- Refused

Have You Been Diagnosed with AIDS or Positive for HIV?

- No
- Yes
- Don't know
- Refused

Do You Have a Mental Health Problem?

- No
- Yes
- Don't know
- Refused

Do You Have a Drug or Alcohol Problem?

- No
- Yes
- Don't know
- Refused

Have You Been a Victim of Domestic Violence?

- No
- Yes
- Don't know
- Refused

Are You a Runaway Youth?

- No
- Yes
- Don't know
- Refused

Are You 62 Years of Age or Older?

- No
- Yes
- Don't know
- Refused

If You Have No Income, Why Are You Not On General Relief?

- N/A
- Sanction
- Time limits

- Employment
- Other

4. INCOME AND BENEFITS

Sources of Income: List all household sources of income. Include employment income, all income from Social Security and SSI, pensions, disability, unemployment insurance, alimony, child support, compensation from people not living with applicant. List all sources of income. Do not all of a sudden decide you have other sources of income if your case is denied – they will not be accepted.

Name of Person Receiving Income (include everyone receiving income)	Income Source (see the list above for examples to include)	Monthly Gross Amount (before taxes)

Total Monthly Income: _____

Total Yearly Income: _____

How Do You Pay Your Bills?

Checking Account No: _____

Savings Account No: _____

If you do not have a checking account you must provide money order receipts or other valid commercially issued receipts to prove your payments.

Unexpected Situation or Unusually High Expenses (please explain what caused you this financial crisis)

- Unemployment _____
- Medical _____
- Utility _____
- Legal _____
- Auto _____
- Other _____

Area Median Income for San Bernardino County								
Family Size	1 Person	2 Person	3 Person	4 Person	5 Person	6 Person	7 Person	8 Person
Income Limit (before taxes)	\$23,300	\$26,650	\$29,950	\$33,300	\$35,950	\$38,650	\$41,300	\$43,950

Does this client fall under the 50% AMI criteria? Yes No

5. HOUSEHOLD INFORMATION

Number of Persons in Household: _____ Enter total number of individuals – both adults and children – who will be residing together in the same housing unit under this rental assistance program.

Additional Household Members Other Than Applicant:

1) Name: _____ Relationship: _____

SS#: _____ DOB: _____ Age: _____

If adult, education level completed: _____ If child, grade in now: _____

Gender: Male
 Female
 Transgender

Disabled: Yes
 No

Ethnicity: Non-Hispanic/Non-Latino
 Hispanic/Latino

Veteran: Yes
 No

Race: American Indian/Alaska Native
 Black or African-American
 White

Asian
 Native Hawaiian or Pacific Island
 Other Multi-Racial

Insurance: Medi-Cal
 Medi-Caid
 Medi-Care
 MIA

None
 Unknown
 HMO

2) Name: _____ Relationship: _____

SS#: _____ DOB: _____ Age: _____

If adult, education level completed: _____ If child, grade in now: _____

Gender: Male
 Female
 Transgender

Disabled: Yes
 No

Ethnicity: Non-Hispanic/Non-Latino
 Hispanic/Latino

Veteran: Yes
 No

Race: American Indian/Alaska Native
 Black or African-American
 White

Asian
 Native Hawaiian or Pacific Island
 Other Multi-Racial

Insurance: Medi-Cal
 Medi-Caid
 Medi-Care
 MIA

None
 Unknown
 HMO

Household Members Continued:

3) Name: _____ **Relationship:** _____

SS#: _____ **DOB:** _____ **Age:** _____

If adult, education level completed: _____ If child, grade in now: _____

Gender: Male Female Transgender

Disabled: Yes No

Ethnicity: Non-Hispanic/Non-Latino Hispanic/Latino

Veteran: Yes No

Race: American Indian/Alaska Native Black or African-American White

Asian Native Hawaiian or Pacific Island Other Multi-Racial

Insurance: Medi-Cal Medi-Caid Medi-Care MIA

None Unknown HMO

4) Name: _____ **Relationship:** _____

SS#: _____ **DOB:** _____ **Age:** _____

If adult, education level completed: _____ If child, grade in now: _____

Gender: Male Female Transgender

Disabled: Yes No

Ethnicity: Non-Hispanic/Non-Latino Hispanic/Latino

Veteran: Yes No

Race: American Indian/Alaska Native Black or African-American White

Asian Native Hawaiian or Pacific Island Other Multi-Racial

Insurance: Medi-Cal Medi-Caid Medi-Care MIA

None Unknown HMO

Household Members Continued:

5) Name: _____ **Relationship:** _____

SS#: _____ **DOB:** _____ **Age:** _____

If adult, education level completed: _____ If child, grade in now: _____

Gender: Male
 Female
 Transgender

Disabled: Yes
 No

Ethnicity: Non-Hispanic/Non-Latino
 Hispanic/Latino

Veteran: Yes
 No

Race: American Indian/Alaska Native
 Black or African-American
 White

Asian
 Native Hawaiian or Pacific Island
 Other Multi-Racial

Insurance: Medi-Cal
 Medi-Caid
 Medi-Care
 MIA

None
 Unknown
 HMO

6) Name: _____ **Relationship:** _____

SS#: _____ **DOB:** _____ **Age:** _____

If adult, education level completed: _____ If child, grade in now: _____

Gender: Male
 Female
 Transgender

Disabled: Yes
 No

Ethnicity: Non-Hispanic/Non-Latino
 Hispanic/Latino

Veteran: Yes
 No

Race: American Indian/Alaska Native
 Black or African-American
 White

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Insurance: Medi-Cal
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None
 Unknown
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Use additional sheets as necessary.

6. SERVICES REQUESTED

- Rent - Homeless Prevention
- Rent – Rapid Re-Housing
- Utility Payment Assistance
- Hotel/Motel Voucher

Authorization

I am the individual to whom the information in this application applies. I represent that the information provided in this application is true, correct, and current to the best of my knowledge and belief. I know that if I make any representations which I know are false, I may be disqualified from initial or continuing eligibility in the HDDVP HPRP Emergency Services Program for which I am applying.

I certify that I am not receiving rent or utility assistance from any other government agency or program, or any other non-profit social service agency.

I further agree to inform HDDVP of any changes in the information provided which may occur during the application process and/or any period in which rental or utility assistance is received under this program. If HDDVP cannot contact me by phone due to invalid number, or I do not return their phone call requesting information within 24 hours, I acknowledge I will be terminated.

Applicant Signature: _____ Date: _____

Please read and initial each item below. We want to assist you if you qualify. However, there are limited funds and a very specific population this program will assist.

_____ You must cancel an appointment at least 1 full business day (24 hours) in advance. If you miss two appointments without cancelling ahead of time by leaving a clearly spoken voicemail with your name and phone number we will not be able to serve you. If you are 15 minutes late for an appointment we may have to reschedule, if we can see you that day because someone else didn't show up we will do that, just wait patiently.

We schedule each client for 45 minute appointments, if you don't show up, show up late, or keep showing up without the required documents you have prevented others from receiving help.

_____ If you have your phone disconnected for any reason get in touch with us immediately to leave a phone number so we can at least get a message to you. If we call you and get a message that your phone is no longer in service and there is no other way to reach you, further assistance will be terminated immediately.

_____ If during any conversation you become verbally abusive, rude, or threatening all services will be terminated. Your name and phone number will be put on a "DO NOT SERVE" list that is distributed to other agencies providing assistance throughout San Bernardino County.

_____ Do not falsify any documents or your name and phone number will be put on a "DO NOT SERVE" list that is distributed to other agencies providing assistance throughout San Bernardino County. Falsified documents also become the property of the Federal Government and their penalties are harsh and expensive.

_____ You agree to pay the remaining portion of rent to your landlord or utility bill to the utility company after the HPRP payment or pledge is initiated. Failure to do so will halt any further payments until your obligation is fulfilled.

_____ There are rules and regulations to this program that have been instituted by HUD (the Federal Government) and San Bernardino County to help a certain population. They ask for documentation and back-up paperwork. We will do everything we can to help you qualify, but if you don't we will try to refer you to other programs that might assist you.

_____ When you call the Emergency Assistance phone number leave one message. Speak slowly and clearly – it is up to you to make sure we can understand everything you say. State your first and last names and your phone number. Leave a brief message. We will call you back, if you don't answer we will leave a message.

Client Signature: _____

Client Phone: _____