



INTAKE & APPLICANT INFORMATION

Applicant Information:

Full Legal Name:

Date of Birth:

SSN (last 4):

Phone:

Current Address / Living Situation:

Current Housing Status:

☐ Homeless/Unsheltered

☐ Transitional Housing

☐ Emergency Shelter

☐ Doubled-Up/Couch Surfing

☐ Institution (hospital/jail)

☐ Other:

Emergency / Next of Kin Contact

Primary Contact Name

Relationship

Phone Number



INTAKE & APPLICANT INFORMATION

Accommodation & Support Needs

Does applicant require reasonable accommodation (ADA)?

☐ Yes

☐ No

If yes, describe accommodation requested:

Referral Source

Referred By (agency/individual):

Referral Contact Phone/Email:

Reason for Referral:

APPLICANT ACKNOWLEDGEMENT

I certify that the information provided in this application is true and complete to the best of my knowledge. I understand that providing false information may result in denial or termination of housing assistance

Applicant Signature:

Date

Case Manager Signature:

Date



HOUSING NEEDS ASSESSMENT

Housing History & Stability

Date: _____

Applicant Name: _____

Number of moves in past 12 months: _____

Level of Need (check one per item)

Independent living skills	☐ None	☐ Mild	☐ Moderate	☐ Severe
Financial management skills	☐ None	☐ Mild	☐ Moderate	☐ Severe
Employment stability	☐ None	☐ Mild	☐ Moderate	☐ Severe
Social support network	☐ None	☐ Mild	☐ Moderate	☐ Severe
Physical health needs	☐ None	☐ Mild	☐ Moderate	☐ Severe
Mental health/wellness needs	☐ None	☐ Mild	☐ Moderate	☐ Severe
Substance use concerns	☐ None	☐ Mild	☐ Moderate	☐ Severe

Specific Needs Identified (check all that apply)

- | | |
|--|--|
| ☐ Transportation assistance | ☐ Childcare support |
| ☐ Employment/job search | ☐ Benefits enrollment (SNAP/Medicaid/SSI) |
| ☐ Legal assistance | ☐ Medical/dental care |
| ☐ Mental health services | ☐ Substance use treatment |
| ☐ Education/GED | ☐ Life skills coaching |

Case manager Summary

Overall assessment and recommended service plan priorities

Case Manager Signature: _____



INCOME & BENEFITS VERIFICATION

Income Sources:

Applicant Name: _____

SOURCE	MONTHLY AMOUNT	VERIFICATION DATE	VERIFICATION ATTACHED?
Employment / Wages	_____	_____	☐
Social Security (SSI/SSDI)	_____	_____	☐
TANF / Cash Assistance	_____	_____	☐
Unemployment Benefits	_____	_____	☐
Veterans Benefits	_____	_____	☐
Child Support	_____	_____	☐
Pension/Retirement	_____	_____	☐
Other	_____	_____	☐
Total Monthly Household Income:	_____		

Benefit Program Enrollment

- | | | |
|---|--|--|
| ☐ SNAP (Food Stamps) | ☐ SSI/SSDI | ☐ Medicaid |
| ☐ Medicare | ☐ LIHEAP (Utility Assistance) | ☐ Section 8 / Housing Voucher |
| ☐ WIC | ☐ Other | |

Financial Contribution Calculation

Program contribution rate (% of income): _____

Calculated monthly contribution amount: _____

Notes / Discrepancies:

Case Manager Signature: _____



CASE MANAGER REFERRAL FORM

Resident Name:

Referral Date:

Referring Party

Referring Case Manager:

Receiving Program / Service

Agency / Program Name:

Service Type:

Reasons for Referral (check all that apply)

- | | | | |
|---|--|--|--------------------------------|
| ☐ Mental health services | ☐ Childcare | ☐ Legal aid | ☐ Other |
| ☐ Employment services | ☐ Financial counseling | ☐ Benefits enrollment | |
| ☐ Medical/dental care | ☐ Substance use treatment | ☐ Education/GED | |

Clinical Situational Summery

Relevant background, urgency, and goals for the referral:

Consent to share information:

Resident has consented to release of relevant information to the receiving program.

- ☐ Yes, consent obtained
- ☐ No - referral is informational only, no PHI shared

Case Manager Signature: _____



EMERGENCY CONTACT & HEALTH DISCLOSURE

Resident Name:

Primary Emergency Contact:

Name:

Relationship:

Phone:

Email address:

Secondary Emergency Contact:

Name:

Relationship:

Phone:

Email address:

Health Disclosure (Voluntary)

This section is optional. Information provided here is used only to respond appropriately in a medical emergency and is not used for eligibility decisions.

Primary Physician:

Known Allergies:

Current Medications:

Medical Conditions Relevant to Emergency Response:

Mobility or communication accommodations first responders should know about:

☐ I authorize program staff to share the above information with emergency responders or medical personnel if needed to protect my health or safety

Resident Signature: _____