Supportive Housing Client Intake Form

Participant Intake & Enrollment Application

PROGRAM / COMPANY NAME: _____

Date of Intake: _____ **Referral Agency / Name of Referrer:** _____

1 PARTICIPANT INFORMATION

Full Name: _____

Date of Birth: _____ **Age:** _____ **SSN (Last 4 digits):** _____

Phone Number: _____ **Email Address:** _____

Gender:

☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to say

Emergency Contact Name: _____ **Relationship:** _____

Emergency Contact Phone: _____

2 CURRENT LIVING SITUATION

☐ Homeless ☐ Couch surfing / Staying with others ☐ Transitional Housing ☐ Jail / Prison Release

☐ Hospital / Rehab

☐ Other: _____

3 REFERRAL SOURCE (IF APPLICABLE)

☐ Self ☐ Parole / Probation ☐ Hospital or Treatment Center ☐ Family / Friend

☐ Agency: _____

Referring Contact Name: _____ **Phone / Email:** _____

4 BRIEF SUMMARY OF SITUATION / REASON FOR HOUSING NEED

5 MEDICAL & MENTAL HEALTH HISTORY

Medical & mental health history (list below):

Mental health diagnosis (if any): _____

Substance use history (if any):

☐ Alcohol ☐ Drugs ☐ None

If yes, explain: _____

6 LEGAL BACKGROUND

Are you currently on parole or probation?

☐ Yes ☐ No

PO Name: _____ **PO Phone Number:** _____

Are you a registered sex offender?

☐ Yes ☐ No

Additional notes: _____

7 INCOME INFORMATION

Do you have a source of income?

☐ Yes ☐ No

☐ SSI ☐ SSDI ☐ Employment ☐ Other: _____

Monthly Income Amount (if any): $ _____

8 HOUSING PREFERENCES OR NEEDS

Any disabilities or accommodations needed?

☐ Yes ☐ No

If yes, explain: _____

Preferred Room Type:

☐ Shared Room ☐ Private Room (if available)

9 INDEPENDENT LIVING & FUNCTIONALITY ACKNOWLEDGMENT

Our program is designed for individuals who are high-functioning and capable of living independently. **This is not a personal care home, nursing home, or assisted living facility.** We do not provide medical care, personal assistance, or supervision.

You must be able to manage your own:

- Personal hygiene and grooming
- Meal preparation and eating
- Medication (unless managed by an outside provider)
- Mobility and transportation arrangements
- Housekeeping and laundry
- Daily living responsibilities

If you require medical or personal care services, they must be provided by a licensed outside agency or caregiver, arranged and paid for separately.

Can you live independently and manage your Activities of Daily Living (ADLs) without assistance?

☐ Yes

☐ No – Please explain: _____

Do you currently have or need a home health care provider or outside support service?

☐ Yes – Agency Name (if applicable): _____

☐ No

☐ I understand and agree that this program provides **housing only**. I will be responsible for my personal care, medical needs, and daily living tasks. I will not hold the program responsible for services outside the scope of independent housing.

Participant Initials: _____ **Date:** _____

10 PROGRAM AGREEMENT PREVIEW

- [ ] I understand that if accepted, I must follow all house rules, expectations, and participate in case management or program-related check-ins.
- [ ] I acknowledge that violating rules may result in a strike or dismissal from the program.

11 APPLICANT DECLARATION

I certify that the above information is true to the best of my knowledge. I understand that this intake does not guarantee placement, and my application will be reviewed by staff.

Participant Name: _____

Participant Signature: _____ **Date:** _____

FOR OFFICE USE ONLY

Staff Name: _____ **Date Received:** _____

Staff Signature: _____