

MFIN Intake Form - INDIVIDUAL

Intake Date _____

Client #: _____

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Last Name				Gender			
First Name				Male		<input type="checkbox"/>	
Middle Name (optional)				Female		<input type="checkbox"/>	
Suffix (optional)				Transgendered-M to F		<input type="checkbox"/>	
Social Security Number				Transgendered-F to M		<input type="checkbox"/>	
Date of Birth				Gender Non-Conforming		<input type="checkbox"/>	
Where do you sleep at night:						Phone:	
Race (choose all that apply)				Ethnicity			
White		<input type="checkbox"/>		Hispanic / Latino		<input type="checkbox"/>	
Black or African-American		<input type="checkbox"/>		Non-Hispanic / Non-Latino		<input type="checkbox"/>	
Asian		<input type="checkbox"/>					
American Indian or Alaskan Native		<input type="checkbox"/>					
Native Hawaiian or Pacific Islander		<input type="checkbox"/>					
		DK <input type="checkbox"/> Ref <input type="checkbox"/> DNC <input type="checkbox"/>					
Military History							
Have you served on active duty in the military (adults only)		<input type="checkbox"/> Y <input type="checkbox"/> N		Year entered Military Service		_____	
				Year separated Military Service		_____	
Did you serve in:		<input type="checkbox"/> World War II <input type="checkbox"/> Korean War <input type="checkbox"/> Vietnam War <input type="checkbox"/> Persian Gulf War <input type="checkbox"/> Afghanistan <input type="checkbox"/> Iraq-Iraqi Freedom <input type="checkbox"/> Iraq-New Dawn <input type="checkbox"/> Other		Branch of Military		<input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marines <input type="checkbox"/> Coast Guard	
				Discharge Status		<input type="checkbox"/> Honorably <input type="checkbox"/> General under honorable conditions <input type="checkbox"/> Under other than honorable conditions <input type="checkbox"/> Bad Conduct <input type="checkbox"/> Dishonorably <input type="checkbox"/> Uncharacterized	
Where did you sleeping last night?				How long have you been sleeping in this type of situation?			
Place not meant for habitation		<input type="checkbox"/>		One night or less		<input type="checkbox"/>	
Emergency shelter incl. hotel/motel paid by voucher		<input type="checkbox"/>		Two to six nights		<input type="checkbox"/>	
Safe Haven (this is not a DV shelter)		<input type="checkbox"/>		One week or more, but less than one month		<input type="checkbox"/>	
Foster Care home or foster care group home		<input type="checkbox"/>		One month or more but less than 90 days		<input type="checkbox"/>	
Hosp. or other res. non-psychiatric med. facility		<input type="checkbox"/>		90 days or more but less than one year		<input type="checkbox"/>	
Jail, prison, or juvenile detention facility		<input type="checkbox"/>		One year or longer		<input type="checkbox"/>	
Long-term care facility or nursing home		<input type="checkbox"/>		Approx. Date this Episode of Homelessness Started:			
Psychiatric hospital or other psychiatric facility		<input type="checkbox"/>		_____			
Substance abuse treatment facility or detox center		<input type="checkbox"/>		Number of times on the streets, in ES or Safe Haven in the past 3 years			
Host Home (non-crisis)		<input type="checkbox"/>		<input type="checkbox"/> One Time		<input type="checkbox"/> Two Times	
Hotel or motel paid w/o emergency shelter voucher		<input type="checkbox"/>		<input type="checkbox"/> Four+ Times		DK <input type="checkbox"/> Ref <input type="checkbox"/> DNC <input type="checkbox"/>	
Owned by client, with no subsidy		<input type="checkbox"/>		Total number of months homeless on the streets, in ES or Safe Haven in the past three years			
Owned by client, with other ongoing subsidy		<input type="checkbox"/>		<input type="checkbox"/> 1 mth (this time is 1 st month)		<input type="checkbox"/> 2 mth <input type="checkbox"/> 3 mth	
Permanent housing (other than RRH) for formerly homeless persons		<input type="checkbox"/>		<input type="checkbox"/> 4 mth <input type="checkbox"/> 5 mth		<input type="checkbox"/> 6 mth <input type="checkbox"/> 7 mth	
Rental by client, with no subsidy		<input type="checkbox"/>		<input type="checkbox"/> 8 mth <input type="checkbox"/> 9 mth		<input type="checkbox"/> 10 mth <input type="checkbox"/> 11 mth	
Rental by client, with HCV voucher (tenant or project based)		<input type="checkbox"/>		<input type="checkbox"/> 12 mth		<input type="checkbox"/> 12+ mth	
Rental by client in a public housing unit		<input type="checkbox"/>				DK <input type="checkbox"/> Ref <input type="checkbox"/> DNC <input type="checkbox"/>	
Rental by client, with VASH housing subsidy		<input type="checkbox"/>		Have you been homeless the entire time in this county?			
Rental by client, with GPD TIP subsidy		<input type="checkbox"/>		<input type="checkbox"/> Y <input type="checkbox"/> N			
Rental by client, with RRH or equivalent subsidy		<input type="checkbox"/>		If NO, where were you homeless before?		<input type="checkbox"/> Levy <input type="checkbox"/> Marion <input type="checkbox"/> Pasco <input type="checkbox"/> Polk <input type="checkbox"/> Orange <input type="checkbox"/> Other	
Res project/halfway house with no homeless criteria		<input type="checkbox"/>					
Staying/living in family member's room, apt, or house		<input type="checkbox"/>					
Staying/living in friend's room, apartment, or house		<input type="checkbox"/>					
Transitional housing for homeless persons		<input type="checkbox"/>					
Client Doesn't Know (DK), Refused (Ref), Data Not Collected (DNC)		DK <input type="checkbox"/> Ref <input type="checkbox"/> DNC <input type="checkbox"/>					

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Disabling Conditions and Barriers (all clients)					
Do you have a Disabling Condition? <input type="checkbox"/> Y <input type="checkbox"/> N					
For the next 6 items, the phrase "Long Term" means is the condition expected to be of long-continued and indefinite duration and does it substantially impair ability to live independently.					
Physical Disability	<input type="checkbox"/> Y <input type="checkbox"/> N Long Term <input type="checkbox"/> Y <input type="checkbox"/> N	Development Disability	<input type="checkbox"/> Y <input type="checkbox"/> N Long Term <input type="checkbox"/> Y <input type="checkbox"/> N	Chronic Health Condition	<input type="checkbox"/> Y <input type="checkbox"/> N Long Term <input type="checkbox"/> Y <input type="checkbox"/> N
HIV/AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N Long Term <input type="checkbox"/> Y <input type="checkbox"/> N	Mental Illness	<input type="checkbox"/> Y <input type="checkbox"/> N Long Term <input type="checkbox"/> Y <input type="checkbox"/> N	Substance Abuse Problem	<input type="checkbox"/> Drug <input type="checkbox"/> Alcohol <input type="checkbox"/> Both <input type="checkbox"/> N Long Term <input type="checkbox"/> Y <input type="checkbox"/> N
Victim of Domestic Violence	<input type="checkbox"/> Y <input type="checkbox"/> N	Are you currently fleeing?	<input type="checkbox"/> Y <input type="checkbox"/> N		
Last Occurrence	<input type="checkbox"/> In past 3 months <input type="checkbox"/> 3-6 months ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> 1 year ago or more				
Receiving Income from Any Source? <input type="checkbox"/> Y <input type="checkbox"/> N <i>(applies to adults only; enter amount rec'd on a regular monthly basis; if children have income, add to Head of Household)</i>					
Earned Income	\$ _____		Veteran's Pension	\$ _____	
Unemployment Income	\$ _____		Employment Pension	\$ _____	
Worker's Compensation	\$ _____		TANF (Temp Asst for Needy Fam)	\$ _____	
Private Disability Insurance	\$ _____		General Assistance (GA)	\$ _____	
Veteran's Disability Payment	\$ _____		Spousal Support	\$ _____	
Social Security Disability Insurance (SSDI)	\$ _____		Child Support	\$ _____	
Supplemental Security Income (SSI)	\$ _____		Other Cash Income	\$ _____	
Social Security Retirement	\$ _____				
Receiving non-cash benefits? (adults only) <input type="checkbox"/> Y <input type="checkbox"/> N					
SNAP	<input type="checkbox"/>	TANF Transportation	<input type="checkbox"/>		
WIC	<input type="checkbox"/>	Other TANF Benefit	<input type="checkbox"/>		
TANF Childcare	<input type="checkbox"/>	Other Non-Cash Benefit	<input type="checkbox"/>		
Covered by Health Insurance (all clients) <input type="checkbox"/> Y <input type="checkbox"/> N					
Medicaid	<input type="checkbox"/>	Medicaid Plan:	<input type="checkbox"/>	Medicaid Plan #	_____
Medicare	<input type="checkbox"/>	Wellcare	<input type="checkbox"/>		
SCHIP	<input type="checkbox"/>	Staywell	<input type="checkbox"/>		
VA Medical	<input type="checkbox"/>	Staywell for Kids	<input type="checkbox"/>		
Employer Provided	<input type="checkbox"/>	Humana Medical Plan	<input type="checkbox"/>		
Obtained through COBRA	<input type="checkbox"/>	United Healthcare	<input type="checkbox"/>		
Private Pay Health Insurance	<input type="checkbox"/>	Sunshine Health	<input type="checkbox"/>		
State Health Insurance for Adults	<input type="checkbox"/>				
Indian Health Services Program	<input type="checkbox"/>				
Other Health Insurance	<input type="checkbox"/>				