EXODUS HOMES
RESIDENT APPLICATION

APPROVED_____ APPLICANT NOTIFIED_____ ADMISSION DATE: _____
DENIED_____ APPLICANT NOTIFIED_____ RELEASE DATE: _____
OPUS/DOC #:_____
SOR RECORD CHECK_____ NCDPS RECORD CHECK:_____

NAME:_____ ADDRESS:_____

CITY:_____STATE_____ZIP CODE_____

HAVE YOU EVER BEEN A RESIDENT OF CATAWBA, BURKE, ALEXANDER OR CALDWELL COUNTIES?: ____yes ____no

TELEPHONE: HOME_____WORK_____

AGE:_____BIRTHDATE:_____SEX:_____RACE_____RELIGION:_____

MARITAL STATUS:_____ MAIDEN NAME:_____
(If married give spouse name)

OCCUPATION: _____ SSN:_____

ABLE BODIED____ or DISABLED_____ AMOUNT OF DISABILITY_____

DO YOU HAVE MEDICAID?_____

U.S. VETERAN: _____yes _____no

IF YES, WHAT BRANCH_____

HONORABLE DISCHARGE: _____ DISHONORABLE DISCHARGE: _____

HAVE YOU EVER BEEN HOMELESS? _____yes _____no

IF SO, HOW MANY TIMES? _____

WHAT LOCATIONS:

_____
_____
_____

CHILDREN INFORMATION:

NAME	**AGE**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

CUSTODY OF CHILDREN:

_____
_____
_____

IS CHILD CURRENTLY ENROLLED IN SCHOOL? ☐ YES ☐ NO

OTHER AGENCIES INVOLVED: ☐ DSS ☐ JUVENILE COURT ☐ GAL ☐ OTHER

NOTIFY IN CASE OF EMERGENCY:

NAME:_____ ADDRESS:_____
CITY: _____ STATE:_____ ZIPCODE:_____
TELEPHONE: HOME:_____ WORK:_____
RELATIONSHIP:_____

REHAB PROGRAMS COMPLETED (NAME AND CITY):

_____ _____
_____ _____
_____ _____

NAME OF CURRENT REHAB PROGRAM: _____

NAME OF COUNSELOR: _____ TELEPHONE #_____

RELEASE DATE: _____

SOBRIETY AND/OR CLEAN DATE: _____

REASON FOR APPLYING TO EXODUS HOUSE:_____
_____
_____
_____

SUBSTANCE ABUSE ADMISSION ASSESSMENT

SYMPTOMS: ☐NONE ☐ATTEMPTS TO CUT DOWN ☐ INCREASED TOLERANCE ☐WITHDRAWAL ☐ FAMILY/RELATIONSHIP PROBLEMS ☐ JOB PROBLEMS ☐GUILTY ABOUT ACTIONS WHILE USING

SUBSTANCE	CODE	ROUTE	FREQUENCY WHEN USING	AGE	WITHDRAWAL SYMTOMS/SPECIFY

SUBSTANCE CODES:

00 None
01 Alcohol
02 Cocaine/Crack
03 Marijuana/Hashish
04 Heroin
05 Methadone
06 Opiates/Synthetics
07 PCP
08 Hallucinogens
09 Math Amphetamine
10 Amphetamines
11 Stimulants
12 Benzodiazepine
13 Tranquilizers
14 Barbiturates
15 Sedatives
16 Inhalants
17 Over-the-Counter

ROUTE CODES:

1 ORAL 2 SMOKING 3 INHALING 4 INJECTION 5 OTHER

FRENQUENCY CODES:

00 DRUG NOT USED DURING THE PAST MONTH
01 DRUG USED 1-3 TIMES IN THE PAST MONTH
02 DRUGS USED 1-2 TIMES PER WEEK
03 DRUGS USED 3-6 TIMES PER WEEK
04 DRUGS USED DAILY

MEDICAL HISTORY:

DIABETES: ☐YES ☐NO : (IF YES, PLEASE EXPLAIN)

HIGH BLOOD PRESSURE: ☐YES ☐NO : (IF YES, PLEASE EXPLAIN)

HEART DISEASE: ☐YES ☐NO : (IF YES, PLEASE EXPLAIN)

STROKE: ☐YES ☐NO : (IF YES, PLEASE EXPLAIN)

SEIZURES: ☐YES ☐NO : (IF YES, PLEASE EXPLAIN)

LIVER OR KIDNEY DISEASE: ☐YES ☐NO : (IF YES, PLEASE EXPLAIN)

THYROID OR HORMONAL: ☐YES ☐NO : (IF YES, PLEASE EXPLAIN)

CANCER: ☐YES ☐NO : (IF YES, PLEASE EXPLAIN)

INFECTIOUS DISEASE: (TB, AIDS, HIV, ETC.) ☐YES ☐NO : (IF YES, PLEASE EXPLAIN)

PREGNANT SURGERIES: ☐YES ☐NO : (IF YES, PLEASE EXPLAIN)

LIST PRESCRIBED AND OVER-THE-COUNTER MEDICATIONS NOT LIST ABOVE:

HAVE YOU EVER BEEN A VICTIM OF DOMESTIC VIOLENCE? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE:

MENTAL HEALTH HISTORY:

HAVE YOU EVER BEEN INVOLVED WITH MENTAL HEALTH? ☐ YES ☐ NO

IF ANSWER IS YES PLEASE ANSWER THE FOLLOWING QUESTIONS:

HOW LONG WAS YOUR INVOLVEMENT? WHAT YEAR (S)?

WHAT WAS THE DIAGNOSIS?

_____

_____

WHAT MEDICATIONS, IF ANY, WERE ADMINISTERED?

_____

_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS: ☐ YES ☐ NO
IF SO, NAME AND DOSAGE: _____

_____

_____

IF YOU ARE CURRENTLY TAKING MEDICATION THAT REQUIRES A PSYCHIATRIST FOR REFILLS AND MEDICATION REVIEWS, YOU WILL BE REQUIRED TO BECOME A CLIENT OF ALCOHOL AND DRUG SERVICES OF CATAWBA COUNTY. THEIR FEE IS $25 FOR THE INITIAL ASSESSMENT AND $10 PER MONTH FOR GROUP THERAPY.

WE NEED YOU TO BRING ENOUGH MEDICATION WITH YOU WHEN YOU COME TO LAST UNTIL YOU CAN GET RE-FILLS HERE, WHICH WILL BE 3-4 WEEKS. WILL THIS BE A PROBLEM? PLEASE DESCRIBE:

_____

_____

_____

WE CANNOT ACCEPT RESIDENTS TAKING THE FOLLOWING MEDICATIONS:

ALPROZOLAM (XANAX)
CHLORDIAZPOXIDE (LIBRIUM)
CLONAZEPAM (KLONOPIN)
CLORAZEPATE (TRANXENE)
DIAZEPAM (VALIUM)
FLURAZEPAM (DALMANE)
LORAZEPAM (ATIVAN)
OXAZEPAM (SERAX)
PRAZEPAM (CENTRAX)

TERNAZEPAM (RESTORIL)
TRIAZOLAM (HALCION)

THESE MEDICATIONS ARE HIGHLY ADDICTIVE AND THE POTENTIAL FOR ABUSE EXISTS. THE RESIDENTS SELF-ADMINISTER THEIR OWN MEDICATION. WE FEEL THESE MEDICATIONS ACTUALLY PROLONG A PERSON'S ADDICTION.

TRAUMA, INCLUDING HEAD, PHYICAL/SEXUAL ABUSE: ☐ YES ☐ NO (IF YES, PLEASE EXPLAIN)

_____

_____

ALLERGIES TO ENVIRONMENT, FOOD, OR MEDICATION: ☐ YES ☐ NO (IF YES, PLEASE EXPLAIN)

_____

_____

_____

_____

MENTAL STATUS: ***(To be filled out by counselor or caregiver)*** (CHECK AND DESCRIBE)

DANGER TO SELF:

□ NONE
□ THREATS OF SUICIDE
□ PLAN FOR SUICIDE
□ PREOCCUPATION WITH DEATH
□ SUICIDE ATTEMPTS
□ INABILITY TO CARE FOR SELF

DANGER TO OTHERS:

□ NONE
□ THREATS TO HARM OTHERS
□ PLAN TO HARM OTHERS
□ ATTEMPTS TO HARM OTHERS

ATTITUDE:

□ COOPERATIVE
□ UNCOOPERATIVE
□ SAD/DEPRESSED
□ RESERVED
□ SARCASTIC
□ SUSPICIOUS
□ GUARDED
□ HOSTILE

EMOTIONAL STATE:

□ GOOD
□ TANGENTIAL THINKING
□ EUPHORIC
□ HOSTILE

THOUGHT FORM:

□ NORMAL
□ LOOSE ASSOCIATIONS
□ SLOWNESS IN THOUGHT
□ INCOHERENT
□ CONFUSED
□ FLIGHT OF IDEAS
□ PRESERVATION
□ OTHER

INSIGHT:

□ GOOD
□ FAIR
□ POOR

THOUGHT CONTENT

□ NORMAL
□ UNABLE TO ACCESS
□ IDEAS OF REFERENCE
□ SUSPICIOUS
□ DELUSION
□ HALLUCINATIONS
□ FEELING HOPELESS/HELPLESS

DESCRIPTIONS: ***(To be filled out by counselor or caregiver)***

_____

_____

_____

LEGAL:
HAVE YOU EVER BEEN CONVICTED OF A CRIME?: _____yes _____no

IF SO, PLEASE GIVE NATURE OF CHARGE AND DATE OF CONVICTIONS:_____
_____
_____

DID ANY OF THESE CONVICTIONS LEAD TO INCARCERATION?: _____yes _____no

IF SO, PLEASE LIST INSTITUTION AND YEAR OF CONFINEMENT:
_____
_____
_____

HAVE YOU EVER BEEN CONVICTED OF A SEXUAL OFFENSE? ___yes ___no

IF SO, PLEASE LIST WHERE:
_____
_____
_____

PAROLE OR PROBATION OFFICER:

NAME: _____
ADDRESS: _____
_____
_____
TELEPHONE : _____

SOCIAL WORKER:

NAME: _____
ADDRESS: _____

_____
_____
TELEPHONE: _____

MISCELLANEOUS:

WILL YOU HAVE YOUR ADMISSION FEES? _____Yes _____No
HOW MUCH WILL YOU BRING? _____

DO YOU HAVE A VALID NC DRIVERS LICENSE? _____Yes _____No
IF YES, WHAT IS LICENSE NUMBER? _____

DO YOU HAVE A PICTURE ID? _____Yes _____No
IF YES, WHAT IS YOUR ID NUMBER? _____

DO YOU HAVE FUTURE APPOINTMENTS (i.e. DOCTOR'S, DENTIST, SOCIAL SERVICES) AND/OR COURT DATES? IF YES, PLEASE EXPLAIN:
_____
_____
_____
_____
_____

DO YOU HAVE TRANSPORTATION TO AND FROM THESE APPOINTMENTS? ___ Yes ___ No
OUT OF TOWN APPOINTMENTS WILL BE YOUR RESPONSIBILITY IN MOST CASES.

*****PLEASE CONTINUE TO CALL US EVERY FEW DAYS UNTIL YOU ARRIVE.*****

IF ACCEPTED INTO THIS PROGRAM AND ***IF YOU CAN***, YOU WILL NEED TO BRING THE FOLLOWING ITEMS:

TWIN SHEETS
PILLOW CASES
BLANKETS
CLOTHING (CASUAL AND DRESS)
PERSONAL ARTICLES (TOOTHBRUSH, DEODERANT, ETC.)

WASH CLOTHS, TOWELS, ETC.

ALTHOUGH SOME FOODS ARE PROVIDED, SPECIALITY ITEMS SUCH AS SODA, CAKES, COOKIES, ETC, WILL HAVE TO BE PURCHASED BY THE RESIDENT.

****IMPORTANT NOTICE***

APPLICATION IS NOT COMPLETE UNTIL WE RECEIVE A STATEMENT FROM THE REFERRAL SOURCE STATING THAT THE RESIDENT IS EITHER HOMELESS, OR LACKS THE NECESSARY RESOURCES FOR A RECOVERY LIFESTYLE. PLEASE REFER TO THE AREA/PARAGRAPH CHECKED AND RESPOND ON FACILITY LETTERHEAD. RESIDENTS WILL NOT BE ADMITTED WITHOUT THIS DOCUMENT.

I UNDERSTAND THAT BY COMPLETING THIS APPLICATION, IT ONLY STARTS THE ADMISSIONS PROCESS. I AGREE TO CONTACT EXODUS HOMES WITHIN ONE (1) WEEK, AFTER SUBMITTING THIS APPLICATION, TO SET A DATE FOR THE ADMISSION INTERVIEW, EITHER BY PHONE OR IN PERSON.

SIGNED:_____DATE:_____

PRINT OR TYPE NAME:_____

COMPLETED BY: _____ DATE: _____

DIAGNOSTIC IMPRESSION: (DSM-IV)

_____

_____

_____

_____

_____

SIGNATURE OF QUALIFIED, LICENSED, PROFESSIONAL:

NAME: _____

POSITION: _____

DATE: _____

A copy of License or ID Card must be faxed with application*

Memorandum

EXODUS HOMES

To Whom It May Concern:

Thank you for your referral and interest in our program.

In order for your client's application to be complete there are several things we need from you.

Please include a verification of homelessness in letter or paragraph form, on agency letterhead, stating that the applicant is either homeless or has no resources that would support his/her recovery.

We also need any medical and psychological assessments of the applicant if they are available.

Exodus Homes has many applicants so time is of the essence. If your applicant will need placement within a matter of days, you might want to call 828-324-4870 first to see if we have any openings before taking the time to fill out the application. The sooner we receive this information the faster we can process the application. You can either mail this application back to P.O. Box 3311, Hickory, NC 28603 or FAX it to 828-324-7983

Thank you for your cooperation.

INFORMATION FOR EMPLOYMENT

PERSONAL INFORMATION

Name_____ SSN ____-___-_____

Are you prevented from lawfully becoming employed in this country because of visa or immigration status? _____

EMPLOYMENT DESIRED

Position desired _____

Do you have experience in this field? yes___ no_____ If yes how many years? _____

May we inquire from your previous employer concerning job performance? yes___ no_____

EDUCATION

	Name and Location	***No. of years attended***	***Did you graduated?***
High School	_____	_____	_____
College	_____	_____	_____
Trade, Business Or Corres. Sch.	_____	_____	_____

FORMER EMPLOYERS

DATES	**NAME & ADDRESS**	**SALARY**	**POSITION**	**REASON FOR LEAVING**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Which of these jobs did you like best? _____

What did you like most about this job? _____

FORMER EMPLOYERS

Give the names of three persons not related to you, whom you have known at least one year.

Name ***Address*** ***Years Acquainted***

1._____

2._____

3._____

NC MHMIS CoC Intake Form 3.917B

(SSO, Homeless Prevention, Rapid Rehousing, PH, TH)

HOUSEHOLD INFORMATION

Required Data Entry Fields for All Clients

Answer this section for all persons in household (use additional sheets for larger families)

Full Name	Relationship to Head of Household	SSN	US Military Veteran	Date of Birth mm/dd/yyyy	Gender	Race *(Select all that apply)*
_____ **Name Data Quality** ☐ Full name ☐ Partial, street or code name ☐ Client doesn't know ☐ Client refused	☐ Self (Head of household)	_____ **SSN Data Quality** ☐ Full SSN Reported ☐ Approximate or partial SSN reported ☐ Client doesn't know ☐ Client refused	*(Answer for adults 18+ only)* ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	/ / **DOB Data Quality** ☐ Full DOB reported ☐ Approximate or partial DOB ☐ Client doesn't know ☐ Client refused	☐ Female ☐ Male ☐ Trans Female (MTF or Male to Female) ☐ Trans Male (FTM or Female to Male) ☐ Gender Non-conforming (i.e. not exclusively male to female) ☐ Client doesn't know ☐ Client refused	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Client doesn't know ☐ Client refused

HOUSEHOLD INFORMATION continued…

Answer this section for all persons in household (use additional sheets for larger families)

Name *(Answer for All Persons in HH)*	**Ethnicity**	**Does the client have a disabling condition?**	***Disability Type (Select all that apply)***	**If client has a disabling condition, please answer the following sub-assessment questions.**		
				Disability Determination	*If Yes, to be long-continued and indefinite duration and substantially impairs ability to live independently?*	*Long Term (Yes/ No)*
	☐ Non- Hispanic/ Non-Latino ☐Hispanic/ Latino ☐Client doesn't know ☐Client refused	☐ Yes ☐ No ☐ Client doesn't Know ☐ Client refused	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No

Disability Notes:

_____

HOUSEHOLD INFORMATON continued…

Answer this section for all persons in the household (use additional sheets for larger families)

Name *(Answer for All Persons in HH)*	**Currently Covered by Health Insurance?**	***(If Client has Health Insurance)* Select All Type(s) That Apply**
	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ MEDICAID ☐ MEDICARE ☐ State Children's Health Insurance Program ☐ Veteran Administration (VA) Medical Services ☐ Employer Provided Health Insurance ☐ Health Insurance Obtained through COBRA ☐ Private Pay Health Insurance ☐ State Health Insurance for Adults ☐ Indian Health Services Program ☐ Other (Please Specify: _____)

HOMELESS HISTORY INTERVIEW

Answer the following questions for Head of Household and Adults (Use additional sheets if members of the same household have different homeless histories) Chronic status is determined by a client's history of homelessness, disability status, and the length of time spent on the street, in an emergency shelter or safe haven. Requires a substantiated disability and, continuously homeless for past 12 months to qualify or 4 separate occasions in the past 3 years as long as the combined occasions total at least 12 months. Intake workers should not instruct the client on the length of time/# of episodes necessary to qualify as chronically homeless. Questions should be asked in the exact order they are presented below.

Describe the client's living situation (immediately) prior to project entry?

(Select one Living Situation and answer the corresponding questions in the order in which they appear)

Literally Homeless Situation	Institutional Situation	Transitional/Permanent Housing Situation	Don't Know/ Refused
☐ Place not meant for habitation (e.g. a vehicle, abandoned building, bus/train/subway station, airport, anywhere outside). ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher. ☐ Safe Haven ☐ Interim Housing (e.g. client applied for permanent housing and a unit/voucher has been reserved but client is not able to move in immediately).	☐ Foster care home or foster group home ☐ Hospital or other residential non-psychiatric medical facility ☐ Jail, prison or juvenile detention facility ☐ Long-term care facility or nursing home ☐ Psychiatric hospital or other psychiatric facility ☐ Substance abuse treatment facility or detox center	☐ Hotel or motel paid for without emergency shelter voucher ☐ Owned by client, no ongoing housing subsidy ☐ Owned by client, with ongoing housing subsidy ☐ Permanent housing (other than RRH) for formerly homeless persons ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with VASH housing subsidy ☐ Rental by client, with GPD TIP subsidy ☐ Rental by client, with other ongoing housing subsidy, (including RRH) ☐ Residential project or halfway house with no homeless criteria ☐ Staying or living in a family member's room, apartment or house ☐ Staying or living in a friend's room, apartment or house ☐ Transitional housing for homeless persons (including homeless youth)	☐ Client doesn't know ☐ Client refused

SECTION II	**Length of Stay in Prior Living Situation (i.e. the literally homeless situation identified above)?** ☐ One night or less ☐ Two to six nights ☐ One week or more but less than one month ☐ One month or more but less than 90 days ☐ 90 days or more but less than one year ☐ One year or longer	**Length of Stay in Prior Living Situation (i.e. the institutional situation identified above)?** ☐ One night or less ☐ Two to six nights ☐ One week or more but less than one month ☐ One month or more but less than 90 days ☐ 90 days or more but less than one year ☐ One year or longer **Did you stay in the institutional situation less than 90 days?** ☐ Yes **(If YES – Complete SECTION III)** ☐ No **(If NO- End Homeless History Interview)**	**Length of Stay in Prior Living Situation (i.e. the housing situation identified above)** ☐ One night or less ☐ Two to six nights ☐ One week or more but less than one month ☐ One month or more but less than 90 days ☐ 90 days or more but less than one year ☐ One year or longer **Did you stay in the housing situation less than 7 nights?** ☐ Yes **(If YES – Complete SECTION III)** ☐ No **(If NO – End Homeless History Interview)**	☐ Client doesn't know ☐ Client refused
SECTION III	**N/A** **Complete SECTION IV Below**	**On the night before entering the institutional situation did you stay on the streets, in emergency shelter or a safe haven?** ☐ Yes **(If YES – Complete SECTION IV)** ☐ No **(If NO- End Homeless History Interview)**	**On the night before entering the housing situation did you stay on the streets, in emergency shelter or a safe haven?** ☐ Yes **(If YES – Complete SECTION IV)** ☐ No **(If NO – End Homeless History Interview)**	☐ Client doesn't know ☐ Client refused

*Have the client look back to the date of the last time s(he) "had a place to sleep **other than** the streets, ES, or SH".*
If the client knows the month and year but not the day, the worker may substitute the day of the month with the same day of the month as project entry.

What Counts as a Break in Homelessness?
As the client looks back, there may be breaks in their stay on the streets, ES, or SH. A break in homelessness is considered to be:
- ***7 or more consecutive nights in a Housing Situation** (see Section III above).*
- ***90 or more consecutive days in an Institutional Situation** (see Section II above)*

Follow-up questions:
1. *"Did you stay anywhere other than on the streets, in emergency shelter, or safe haven for less than 7 nights" (if not an institution). or*
2. *"Were you in jail/hospital/other Institution less 90 days" (if break is an institution).*

If 1 or 2 is yes, include all those days in the client's total number of days homeless and continue back to the next break in homelessness.

SECTION IV

Approximate date homelessness started: _____(M/D/YYYY)

Regardless of where they stayed last night -- **Number of times the client has been on the streets, in ES, or SH in the past three years, including today**

- ☐ One Time
- ☐ Two Times
- ☐ Three Times
- ☐ Four or more Times
- ☐ Client doesn't know
- ☐ Client refused

Total number of months homeless (on the street, in emergency shelter or safe haven) in the past 3 years?
(e.g. # of cumulative, but not necessarily consecutive months spent homeless)

- ☐ One month (this time is the first month)
- ☐ 2 – 12 months ➔ Must specify # months____
- ☐ More than 12 months
- ☐ Client doesn't know
- ☐ Client refused

Answer the following questions for all Household Members (Unless Otherwise Specified)

Housing Status

- ☐ Category 1 - Homeless
- ☐ Category 2 – At imminent risk of losing federal – Fleeing domestic violence
- ☐ Client refused
- ☐ At-risk of homelessness
- ☐ Category 3 – Homeless only under other statues
- ☐ Client doesn't know housing
- ☐ Stably Housed
- ☐ Category 4

Zip Code of Last Permanent Address: _____ **City of Residence**: _____ **County of Residence:** _____

NC County of Service: _____

Answer the following questions for Head of Household Only

Client Location *(CoC Code):* _____

(Required for all PH and RRH Projects)

This question differentiates between clients who are awaiting placement and those who have moved into any type of permanent housing, regardless of funding source or whether the project is providing rental assistance. The Housing Move-In Date MUST be entered via an Interim Assessment with a timestamp that occurs after the Project Start and before the Project Exit. If client is ***not*** *in housing leave this question blank.*

Housing Move-In Date: _____/_____/_____

**Answer the following questions for HEAD OF HOUSEHOLD and ADULTS only! (Print additional pages where needed) **

INCOME & NON-CASH BENEFITS

Currently receiving income from any source?

☐ Yes ☐ Client doesn't know

☐ No ☐ Client refused

X	Source of Income (Monthly)	Family Member	Amount from Source
	Alimony or Other Spousal Support		$ .00
	Child Support		$ .00
	Earned Income *(Employment)*		$ .00
	General Assistance		$ .00
	Pension or Retirement Income from a Former Job		$ .00
	Private Disability Insurance		$ .00
	Retirement Income from Social Security		$ .00
	SSDI *(Social Security Disability Insurance)*		$ .00
	SSI *(Supplemental Security Income)*		$ .00
	TANF *(Temporary Assistance for Needy Families or FIP grant)*		$ .00
	Unemployment Insurance		$ .00
	VA Service-Connected Disability Compensation		$ .00
	VA Non-Service-Connected Disability Pension		$ .00
	Workers Compensation		$ .00

	Other *(Including Gifts from Friends and Family)* **Specify**:_____		$ .00
	No Financial Resources		**N/A**

Total Monthly Income $_____ (Per Household Member)

Currently receiving any non-cash benefits?

☐ Yes ☐ Client doesn't know

☐ No ☐ Client refused

X	Source of Non-Cash Benefit (Monthly)	Family Member	Amount (If applicable)
	Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps)		$ .00
	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)		$ .00
	TANF Child Care Services		$ .00
	TANF Transportation Services		$ .00
	Other TANF Funded Services		$ .00
	Other Source – **Specify**: _____		$ .00

DOMESTIC VIOLENCE

*Domestic Violence Victim/Survivor should be indicated as **"Yes"** if the person has experienced any domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has taken place **within the individual's or family's primary nighttime residence.***

Domestic Violence Victim/Survivor?

☐ Yes ☐ Client doesn't know
☐ No ☐ Client refused

***(If yes)* When Experience Occurred**

☐ Within the past three months ☐ Six months to one year ago (excluding one year exactly)
☐ Three to six months ago (excluding six more ☐ Client doesn't know months exactly) ☐ One year ago or
☐ Client refused

*Currently fleeing should be indicated as **"Yes"** if the Person is fleeing, or is attempting to flee, the domestic violence situation **or** is afraid to return to their primary nighttime residence.*

***(If yes)* Are you currently fleeing?**

☐ Yes ☐ Client doesn't know
☐ No ☐ Client refused

Overview of domestic violence

_____

Has Client Lived in an Adult Care Home in 2012? ☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused
If Yes) **Adult Care Home Client Lived In Most Recently:**