

# PARTICIPANT INTAKE FORM

NMIS# \_\_\_\_\_

Date:

HEAD OF HOUSEHOLD		ADULT #2	
FIRST NAME		FIRST NAME	
MIDDLE NAME		MIDDLE NAME	
LAST NAME		LAST NAME	
SUFFIX (JR, III)		SUFFIX (JR, III)	
MAIDEN/ALIAS		MAIDEN/ALIAS	
HOUSEHOLD RELATIONSHIP (SELECT ONE)			
EMAIL			
	HEAD OF HOUSEHOLD	ADULT #2	
SOCIAL SECURITY NUMBER (last 4 digits)	Prefer not to answer	Prefer not to answer	
DATE OF BIRTH			
GENDER			
U.S. MILITARY VETERAN			
RACE (select up to 2)			
SEXUAL ORIENTATION			
ETHNICITY			
Do you have a disabling condition?			
As a child, were you ever in Foster Care or are you now?			
Are you a domestic violence victim/survivor?			
Are you currently pregnant or expecting a child (mother or father)?			
Are you currently covered by health insurance?			
What is your highest level of education attained?			

**CHILD INTAKE FORM**

	CHILD #1	CHILD #2	CHILD #3	CHILD #4	CHILD #5
Last Name					
First Name					
Social Security Number (last 4 digits)					
Date of Birth					
Gender					
Race					
Ethnicity					
Disabling Condition	Yes      No	Yes      No	Yes      No	Yes      No	Yes      No
Relationship to Head of Household					
Covered by Health Insurance?					

You will be asked to provide documentation for certain needs such as rent support or unpaid bills, so please bring them with you if you can. Examples include: Shut off notices from utility companies, eviction notices, unpaid medical bills, estimate of health services.

**What is your need? About how much does it cost? Please include as many details as you can.**

**How else can we help? What are your most urgent need? Check all that apply**

<input type="checkbox"/> Daily living (tel., clothes, hygiene)	<input type="checkbox"/> Finances	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Supportive Relationships
<input type="checkbox"/> Dentist	<input type="checkbox"/> General Life Skills	<input type="checkbox"/> Parenting Assistance	<input type="checkbox"/> Transportation
<input type="checkbox"/> Education	<input type="checkbox"/> Housing	<input type="checkbox"/> Physical Health	<input type="checkbox"/> Utilities
<input type="checkbox"/> Employment	<input type="checkbox"/> Legal Help	<input type="checkbox"/> Substance Use	Other: _____

Have you been financially impacted by COVID-19? If yes, please explain

Do you or your children QUALIFY for Medicaid, Title XX, and/or free and reduced lunch, even if you don't receive any of them?\*

Yes                       No                       I don't know                       Prefer not to say

Do you have enough people to count on when you need someone to give you good advice?	Yes <i>If yes, how many?</i>	No	Prefer not to say
Is there someone who doesn't live with you we can contact if we can't reach you?	Yes <i>If yes, please list their name below.</i>	No	Prefer not to say
Name		Phone	Relationship to you

**CLIENT'S RESIDENCE/LAST PERMANENT ADDRESS**

Street Address:				
City:		State:	ZIP Code:	County of Current Residence:
Home Phone #:		Cell Phone #:		Work Phone #:

**Information to be completed by the referral agency and/or Central Navigator**  
**Referral agency- please fill in the following before submitting this form to the Central Navigator:**

<b>Referral Agency Name:</b>	
<b>Referral Staff Member Name:</b>	
<b>Contact Phone Number:</b>	
<b>Contact Email Address:</b>	

**EMPLOYMENT**

Head Of Household Employer		Adult #2 Employer	
Hourly Wage		Hourly Wage	
Hours of Work per Week		Hours of Work per Week	
Are you out of work because of COVID-19?		Are you out of work because of COVID-19?	
Have you applied for Unemployment?		Have you applied for Unemployment?	

**INCOME AND SOURCES -**

**To complete the table below, you must answer 'Yes' or 'No' for each income source.** Answer 'Yes' only if the income source is current and received as of today (i.e. not terminated). Answer 'No' for sources that have been terminated, even if they were received in the past.

**If the response for any source is 'Yes', complete the shaded sections below.** Enter the start date and monthly amount received. If unsure of the exact amount, enter the client's best estimate. Children's income (except earned income) can be included under the Head of Household's information.

Source of Income	Yes	No	If yes, monthly amount from source	Source of Income	Yes	No	If yes, monthly amount from source
Alimony or Other Spousal Support				SSI- Supplemental Security Income			
Annuities, Dividends, Interest				Stipend (foster care, stimulus, etc.)			
Child Support				TANF - Temporary Assistance for Needy Families			
Contributions from Other People				Unemployment			
Earned Income (from job)				VA Non-service Connected Disability Pension			
Pension/Retirement Income from a Former Job				VA Service Connected Disability Compensation			
Self Employment Wages				Worker's Compensation			
SSA - Social Security				Other (specify):			
SSDI -Social Security Disability Income				<b>Total monthly income from all sources</b>			

**PUBLIC BENEFITS**

**To complete the table below, you must answer 'Yes' or 'No' for each public benefit.** Answer 'Yes' only if the non-cash benefit is recurrent and received as of today (i.e. not terminated). Answer 'No' for non-cash benefits that have been terminated, even if they were received in the past.

**If the response for any public benefit is 'Yes', complete the shaded section.**

Source of Public Benefit	Yes	No	Amount from source	Source of Public Benefit	Yes	No	Amount from source
LIHEAP- Low Income Home Energy Program				TANF Child Care Services			
SNAP- Supplemental Nutrition Assistance				TANF Transportation Services			
WIC - Special Supplemental Nutrition Program for Women, Infants, and Children				Other TANF-funded Services			
				Other (specify):			
<b>TOTAL Public Benefits</b>							

MONTHLY LIVING EXPENSES			
Expense	Current	Expense	Current
<b>SAVINGS</b>		<b>FAMILY</b>	
Emergency Plan		Life Insurance	
<b>HOUSING</b>		Day Care/Baby Sitting	
Rent/Mortgage		Allowance/Spending Money	
2nd Mortgage/Mobile Home Space		Alimony/Child Support	
Property Tax		<b>EDUCATION</b>	
Renters/Homeowners Ins		Tuition/School Expense	
Home Furnishings		Music or Other Lessons	
Repairs & Improvements		Student Loans	
<b>UTILITIES</b>		<b>ENTERTAINMENT</b>	
Electricity/Water		Movie Rentals/Netflix	
Gas		Dining Out	
Trash		Sports/Hobbies	
<b>FOOD</b>		Vacations	
Groceries/Household Supplies		Lottery/gambling	
Food Bought at Work		<b>PERSONAL</b>	
School Lunches		Hair Cut/ Nails	
<b>TRANSPORTATION</b>		Toiletries/Cosmetics	
Car Payment #1		Tobacco/Alcohol/Drugs	
Car Payment #2		<b>BUNDLED SERVICES-List here, Or list individually below</b>	
Gasoline		Phone	
Auto Insurance		Cable/Satellite	
Maintenance/Tires		Internet	
Parking/Carpool		<b>MISC</b>	
<b>CLOTHING</b>		Pet Care	
For the Family		Other Debts/Garnishments	
Laundry			
<b>HEALTH CARE</b>			
Health Insurance			
Doctor/Dentist/Eye Care			
Prescriptions		<b>Total Expenses</b>	
Other		<b>Net Monthly Income</b>	

**Community Response and Homeless Management Information System (HMIS) Services Consumers Informed Consent & Release of Information Authorization**

I \_\_\_\_\_ understand information about me and/or my dependents listed in this application is entered into a database system called Clarity Human Services. This system helps to better understand homelessness, to improve service delivery, and to evaluate the effectiveness of services provided. Participation in data collection is a critical component of our community’s ability to provide the most effective services and housing possible. The information that is collected is protected by limiting access to the database and limiting what information may be shared. Access to the data and sharing of the data is in compliance with the standards set by the federal, state, and local regulations governing confidentiality of client records. Every person and agency that is authorized to read or enter information into the system has signed an agreement to maintain the security and confidentiality of the information.

As part of the evaluation of Community Response and the Connected Youth Initiative, your data will be shared with Nebraska Children and their evaluators from Munroe-Meyer Institute. Your name will not be included in any of the information that is provided to the evaluation team. All data is summarized as a group. You can choose not to participate in the evaluation. If you have questions please call Dr. Barbara Jackson at 402-559-5765.

***By signing this form, I authorize the following:***

- The information collected by this agency will be included in Clarity Human Services and only partner agencies, which have entered into an HMIS Agency Participation Agreement, may use it to:
- Produce a client profile at intake that will be shared with collaborating agencies
- Produce aggregate level reports regarding use of services
- Track individual program-level outcomes
- Identify unfilled service needs and plan for enhancements
- Allocate resources among agencies engaged in services
- Have my information shared for the CR/CYI evaluation.

***By signing this form, I authorize the following:***

I authorize the partner agencies and their representatives to share basic information regarding my family members listed below and/or me. I understand that this information is for the purpose of assessing my/our needs for housing, utility assistance, food, counseling, and/or other services.

***The information may consist of the following PPI (Personal Protected Information):***

Name	Family Composition	Housing information
Date of Birth	Income/Non-cash	Health Insurance Status
Social Security	Veteran Status	Client Location Program
Number Gender	Domestic Violence VI-SPDAT	Entry and Exit Services
Ethnicity and Race Residence	Disabling Condition	Provided Assessments
Prior to Project Entry Homeless History	Photo (if applicable)	

***I Understand That:***

- The partner agencies have signed agreements to treat my information in a professional and confidential manner. I have the right to view the client confidentiality policies used by the HMIS partner agencies
- Staff members of the partner agencies who will see my information have signed agreements to maintain confidentiality regarding my information.
- The release of my information does not guarantee that I will receive assistance; my refusal to authorize the use of my information does not disqualify me from receiving assistance.

- My records are protected by federal, state, and local regulations governing confidentiality of client records and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- This authorization will remain in effect until I revoke it in writing, and I may revoke authorization at any time, if I revoke my authorization, all information about me already in the database will remain.
- This release is valid for one year from the date of my signature below.
- I understand I may withdraw my consent at any time.
- I understand that the H3C Response System, Central Navigator, Heartland United Way and its partners and community assistance organizations cannot condition decisions about my treatment, payment, enrollment or eligibility for benefits or services on whether or not I sign this authorization. A copy of this authorization shall be as valid as the original.
- Partner Agencies: A list of the partner agencies within the Nebraska Homeless Management Information System may be viewed prior to signing this form.
- Auditors or funders who have legal rights to review the work of this agency, including the U.S. Department of Housing and Urban Development and Nebraska Department of Health and Human Services Homeless Assistance Program may see my complete file in HMIS if services received are funded by their Department/s.

Please initial one of the following levels of consent:

\_\_\_ I give authorization to have Protected Personal and relevant Information for me and my dependents entered into the NMIS and shared between Partner Agencies.

\_\_\_ I do not consent to the inclusion of personal information in the NMIS about me and any dependents.

\_\_\_\_\_  
**Client Name**

\_\_\_\_\_  
**Client Signature**

\_\_\_\_\_  
**Date Signed**

\_\_\_\_\_  
**Witness Name**

\_\_\_\_\_  
**Witness Signature**

\_\_\_\_\_  
**Date Signed**

## CR/CYI Participant Information Survey

*INSTRUCTIONS: All parts of the Participant Information Survey should be completed at the start of participation in Community Response or the Connected Youth Initiative. The form may be completed with the assistance of a Central Navigator or other service provider, if needed.*

**For each of the following, mark the response that most closely matches how you feel**

<b>Social Connections</b>	<b>A. NOT AT ALL LIKE MY LIFE</b>	<b>B. NOT MUCH LIKE MY LIFE</b>	<b>C. SOMEWHAT LIKE MY LIFE</b>	<b>D. QUITE A LOT LIKE MY LIFE</b>	<b>E. JUST LIKE MY LIFE</b>	<b>NOT APPLICABLE - I DO NOT HAVE KIDS</b>
I have people who believe in me.						
I have someone in my life who gives me advice, even when it's hard to hear.						
When I am trying to work on achieving a goal, I have friends who will support me.						
When I need someone to look after my kids on short notice, I can find someone I trust						
I have people I trust to ask for advice about: (check all that apply)	Money/Bills/Budgeting Relationships and/or my love life Food/Nutrition			Stress, Anxiety, and/or Depression Parenting/My kids (if applicable) None of the above		
<b>Concrete Supports</b>	<b>A. NOT AT ALL LIKE MY LIFE</b>	<b>B. NOT MUCH LIKE MY LIFE</b>	<b>C. SOMEWHAT LIKE MY LIFE</b>	<b>D. QUITE A LOT LIKE MY LIFE</b>	<b>E. JUST LIKE MY LIFE</b>	<b>NOT APPLICABLE - I DO NOT HAVE KIDS</b>
I was able to cover all my expenses last month ( <i>expenses include costs like rent, utility bills, food, transportation, child care, and medical expenses</i> )						
The transportation I use is reliable and consistent						
My housing situation is affordable, safe, and stable						
Over the past three months, my children and I have been able to see a doctor when we needed to. ( <i>If you do not have children, answer for just yourself</i> )						
Over the past three months, I have found a job and/or worked when I needed to						