Intake Form

Date: _____

GENERAL INFORMATION

Reason for Visit:

Full Name:_____

Gender: _____Male _____Female

Marital Status (select one): _____

Address:_____

City:_____State:_____Zip:_____

County:_____ Home Phone:_____

Cell Phone:_____ E-mail:_____

Church Affiliation:_____

Veteran: _____Yes _____No If Yes, details: _____

Homeless: _____Yes _____No If Yes, details: _____

What type of housing do you currently live in? (select one) _____

Subsidized Housing: _____Yes _____No If Yes, details: _____

If renting, Landlord Name: _____ Phone No.:_____

Justice System Involvement (mark all that apply): ____None ____Misdemeanor ____Felony

Referring Agency:_____

Referring Person:_____

Birthdate: ___(provide at meeting)_____ Driver's License #: __(provide at meeting)_____

Primary Transportation: (select one): _____

Soc. Sec. #: __(provide at meeting)_____Spouse:_____

How did your need arise?

How do you plan to be sustainable if you receive assistance?

EMPLOYMENT/EDUCATION/HEALTH INFORMATION

Employed: _____Yes _____No If Yes, Employer: _____

Employment Status (select one): _____

Highest Level of Education: _____

How Long Employed? _____ Hourly Pay Rate: _____

Hours worked per week: _____ Weekly Take Home Pay: _____

Total Household Income _____ Mark One: _____Weekly _____Monthly

Ability to Work (select one): _____

Disabilities: _____

Long-term Disabilities: _____Yes _____No

Primary Health Care Provider: _____

Health Care Insurance Company Name: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

HOUSEHOLD MEMBERS

# of Adults in house: _____ # of Minors in house: _____

OTHER AGENCIES/MINISTRIES

Have you gone to other agencies or churches for help before coming to ATLAS? ___Yes ___No

If so, where? (Please list names of agencies & contact person at each agency)

Do you receive any public assistance? _____No _____Yes If yes, mark ALL that apply:

_____Food Assistance _____WIC _____SSI _____Unemployment

_____SSDI _____Cash Assistance _____State Emergency Assistance

Do you have a CMH caseworker: _____No _____Yes If yes, name: _____

Do you have a DHHS caseworker: ____No _____Yes If yes, name: _____

MEDICAL INFORMATION

Overall Medical Condition (select one): _____

Diagnoses: _____

Are you on medications for (mark all that apply):

_____ADHD/ADD _____Diabetes _____Mood Regulation _____Heart _____Depression

_____Anxiety _____Pain _____Sleep Other: _____

Do you have prescription medication that should be taken regularly? _____No _____Yes

If Yes, are you taking medications as prescribed? _____Yes _____No

If you are not taking medications as prescribed, please state why:

Have you ever applied for disability benefits? _____No _____Yes