San Joaquin Continuum of Care
Intake and Program Enrollment Form

(A separate Intake/Enrollment Form must be completed for all household members as part of Program Enrollment; Head of Household must complete all fields; Children in Household only need shaded/highlighted fields.)

Client name: _____ **Date:**_____

Social Security Number: _____ **Date of Birth:** _____
Quality of Social Security: ☐ Full ☐ Partial ☐ Client doesn't know ☐ Client prefers not to answer
☐ Data not collected

Phone number/email address: _____

Client is: ☐ Head of Household ☐ Unaccompanied Adult (Single Adult) ☐ Other Adult in household
☐ Child in household ☐ Unaccompanied Youth (Youth without any other household members)

Head of Household (if different from "Client Name"): _____

Last Name: _____ **First Name:** _____
Quality of Name: ☐ Full ☐ Partial ☐ Client doesn't know ☐ Client prefers not to answer
☐ Data not collected
Alias: _____ **Middle Name:** _____

Date of Birth: _____
Quality of DoB: ☐ Full ☐ Partial ☐ Client doesn't know ☐ Client prefers not to answer
☐ Data not collected

Current address (if applicable):_____

Sex: ☐ Female ☐ Male ☐ Client prefers not to answer ☐ Client doesn't know ☐ Data not collected

Race and Ethnicity (check all that apply):
☐ American Indian/Native Alaskan/Indigenous ☐ Asian/Asian American ☐ Black/African American/African
☐ Hispanic/Latina/o ☐ Middle Eastern/North African ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Client prefers not to answer ☐ Client doesn't know
☐ Data not collected

Veteran status: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Branch of military: ☐ Army ☐ Air Force ☐ Navy ☐ Marines
☐ Other ☐ Client doesn't know ☐ Client prefers not to answer

Current living situation / Type of Residence (where was household last night?):
☐ Emergency shelter
☐ Transitional housing for homeless
☐ Permanent housing for formerly homeless
☐ Psychological hospital/facility
☐ Substance abuse treatment facility or Detox center
☐ Residential project/halfway house w/ no homeless criteria
☐ Hospital or other medical residential facility
☐ Staying with family members
☐ Staying with friends
☐ Foster care or foster group home
☐ Client doesn't know
☐ Place not meant for human habitation
☐ Hotel/motel paid by HSA or charity
☐ Hotel/motel paid by household
☐ Rental by client with ongoing housing subsidy
☐ Rental by client with no ongoing subsidy
☐ Owned by client with ongoing housing subsidy
☐ Owned by client with no ongoing subsidy
☐ Jail/prison/juvenile detention facility
☐ Long-term care facility
☐ Other (_____)
☐ Client prefers not to answer ☐ Data not collected

Current living situation / Length of stay in prior living situation indicated above:

☐ 1 week or less ☐ 1 week to 1 month ☐ 1 month to 3 months

☐ 3 months to 1 year ☐ more than 1 year ☐ Client doesn't know ☐ Client prefers not to answer

Approximate date this homeless episode started: _____

Number of times been on the streets or in Emergency Shelter during the past three years: _____

Verification provided: ☐ Yes ☐ No

Total number of months on streets or in ES during the past three years: _____

Verification provided: ☐ Yes ☐ No

Last permanent address: _____

Is Client currently being evicted:

☐ Yes ☐ No ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data Not Collected

Has Client been evicted in past 3 years:

☐ Yes ☐ No ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data Not Collected

Number of evictions in past 3 years: _____

Has Client been discharged from an institution (jail, hospital, etc.) in past 6 months:

☐ Yes ☐ No ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data Not Collected

Disabling condition: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client prefers not to answer

Verification provided: ☐ Yes ☐ No

Physical Disability:	☐ Yes	☐ No	☐ Client doesn't know	☐ Client prefers not to answer	☐ Data not collected
If yes, is it long term?	☐ Yes	☐ No	☐ Client doesn't know	☐ Client prefers not to answer	☐ Data not collected
Developmental Disability:	☐ Yes	☐ No	☐ Client doesn't know	☐ Client prefers not to answer	☐ Data not collected
If yes, is it long term?	☐ Yes	☐ No	☐ Client doesn't know	☐ Client prefers not to answer	☐ Data not collected
Chronic Health Condition:	☐ Yes	☐ No	☐ Client doesn't know	☐ Client prefers not to answer	☐ Data not collected
If yes, is it long term?	☐ Yes	☐ No	☐ Client doesn't know	☐ Client prefers not to answer	☐ Data not collected
HIV-AIDS diagnosis:	☐ Yes	☐ No	☐ Client doesn't know	☐ Client prefers not to answer	☐ Data not collected
Mental Health Problem:	☐ Yes	☐ No	☐ Client doesn't know	☐ Client prefers not to answer	☐ Data not collected
If yes, is it long term?	☐ Yes	☐ No	☐ Client doesn't know	☐ Client prefers not to answer	☐ Data not collected

Substance Use Disorder: ☐ Alcohol Use ☐ Drug Use ☐ Both Alcohol and Drug Use ☐ No
☐ Client prefers not to answer ☐ Data not collected

If yes, is it long term?	☐ Yes	☐ No	☐ Client doesn't know	☐ Client prefers not to answer	☐ Data not collected

Victim of Domestic Violence: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Are you currently fleeing?: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client prefers not to answer
☐ Data not collected

Last occurrence: ☐ within past 3 months ☐ 3 to 6 months ago ☐ 6 to 12 months ago
☐ more than 1 year ago ☐ Client doesn't know ☐ Client prefers not to answer

Cash income (in most recent 30 days): *for any income, list amount monthly*

_____ Earned income
_____ Workers compensation
_____ Veteran's service related disability
_____ SSI
_____ Veteran's non-service disability pension
_____ TANF
_____ Spousal support
_____ Other (explain: _____)

_____ Unemployment insurance
_____ Private disability
_____ SSDI
_____ Social Security retirement
_____ Employment pension
_____ General Assistance
_____ Child support

_____ Total cash monthly income

Non-cash benefits (in most recent 30 days): *for any benefits, list amount monthly*

_____ SNAP / Food stamps
_____ WIC
_____ TANF child care
_____ TANF transportation
_____ Other TANF
_____Other (explain: _____)

Health Insurance

☐ Yes ☐ No Medi-Cal
If Yes: Name of Managed Care Plan: _____
Managed Health Plan Number: _____
☐ Yes ☐ No Medicare
☐ Yes ☐ No State Children's Health Insurance Plan
☐ Yes ☐ No VA Medical Services
☐ Yes ☐ No Employer provided health insurance
☐ Yes ☐ No Health insurance through COBRA
☐ Yes ☐ No Private pay health insurance
☐ Yes ☐ No State Health Insurance for Adults
☐ Yes ☐ No Indian Health Services Program Other: _____

Does Client have a Payee or Conservator: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

If Yes: Name and Agency (if any) of Payee/Conservator: _____