MFIN Intake Form - FAMILY

Intake Date _____ **Client #:** _____

Last Name		**Gender**	
First Name		Male	☐
Middle Name *(optional)*		Female	☐
Suffix *(optional)*		Transgendered-M to F	☐
Social Security Number		Transgendered-F to M	☐
Date of Birth		Gender Non-Conforming	☐
Where do you sleep at night:		**Phone:**	

Race *(choose all that apply)*				**Ethnicity**	
White	☐	American Indian or Alaskan Native	☐	Hispanic / Latino	☐
Black or African-American	☐	Native Hawaiian or Pacific Islander	☐	Non-Hispanic / Non-Latino	☐
Asian	☐	Don't Know, Refused	DK ☐ Ref ☐ DNC ☐		

Military History

Have you served on active duty in the military *(adults only)*	☐ Y ☐ N	Year entered Military Service	_____	Year separated Military Service	_____

Did you serve in:			**Branch of Military**		**Discharge Status**	
☐ World War II	☐ Korean War		☐ Army		☐ Honorably	
☐ Vietnam War	☐ Persian Gulf War		☐ Air Force		☐ General under honorable conditions	
☐ Afghanistan	☐ Iraq-Iraqi Freedom		☐ Navy		☐ Under other than honorable conditions	
☐ Iraq-New Dawn	☐ Other		☐ Marines		☐ Bad Conduct	
			☐ Coast Guard		☐ Dishonorably	
					☐ Uncharacterized	

Where did you sleeping last night?		**How long have you been sleeping in this type of situation?**	
Place not meant for habitation	☐	One night or less	☐
Emergency shelter incl. hotel/motel paid by voucher	☐	Two to six nights	☐
Safe Haven (this is not a DV shelter)	☐	One week or more, but less than one month	☐
Foster Care home or foster care group home	☐	One month or more but less than 90 days	☐
Hosp. or other res. non-psychiatric med. facility	☐	90 days or more but less than one year	☐
Jail, prison, or juvenile detention facility	☐	One year or longer	☐
Long-term care facility or nursing home	☐	**Approx. Date this Episode of Homelessness Started:**	
Psychiatric hospital or other psychiatric facility	☐	_____	
Substance abuse treatment facility or detox center	☐	**Number of times on the streets, in ES or Safe Haven in the past 3 years**	
Host Home (non-crisis)	☐		
Hotel or motel paid w/o emergency shelter voucher	☐	☐ One Time ☐ Two Times ☐ Three Times	
Owned by client, with no subsidy	☐	☐ Four+ Times DK ☐ Ref ☐ DNC ☐	
Owned by client, with ongoing subsidy	☐	**Total number of months homeless on the streets, in ES or Safe Haven in the past three years**	
Permanent housing (other than RRH) for formerly homeless persons	☐		
Rental by client, with no subsidy	☐	☐1 mth (this time is 1st month ☐2 mth ☐3 mth ☐4 mth ☐5 mth	
Rental by client, with HCV voucher (tenant or project based)	☐	☐6 mth ☐7 mth ☐8 mth ☐9 mth ☐10 mth ☐11 mth	
Rental by client in a public housing unit	☐	☐12 mth ☐12+ mth DK ☐ Ref ☐ DNC ☐	
Rental by client, with VASH subsidy	☐		
Rental by client, with GPD TIP subsidy	☐	Have you been homeless the entire time in this county? ☐ Y ☐ N	
Rental by client, with other ongoing subsidy incl. RRH	☐		
Res project/halfway house with no homeless criteria	☐	If NO, where were you homeless before? ☐ Citrus ☐ Hernando ☐ Lake ☐ Sumter ☐ Levy ☐ Marion ☐ Pasco ☐ Polk ☐ Orange ☐ Other	
Staying/living in family member's room, apt, or house	☐		
Staying/living in friend's room, apartment, or house	☐		
Transitional housing for homeless persons	☐		
Client Doesn't Know (DK), Refused (Ref), Data Not Collected (DNC)	DK ☐ Ref ☐ DNC ☐		

Disabling Conditions and Barriers *(all clients)*

Do you have a Disabling Condition?	☐ Y ☐ 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	☐ Y ☐ N Long Term ☐ Y ☐ N	Development Disability	☐ Y ☐ N ☐ Long Term ☐ Y ☐ N	Chronic Health Condition	☐ Y ☐ N ☐ Long Term ☐ Y ☐ N
HIV/AIDS	☐ Y ☐ N Long Term ☐ Y ☐ N	Mental Illness	☐ Y ☐ N Long Term ☐ Y ☐ N	Substance Abuse Problem	☐ Drug ☐ Alcohol ☐ Both ☐ No Long Term ☐ Y ☐ N

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Victim of Domestic Violence	☐ Y ☐ N	Are you currently fleeing?	☐ Y ☐ N
Last Occurrence	☐In past 3 months ☐ 3-6 months ago ☐ 6-12 months ago ☐1 year ago or more		

Receiving Income from Any Source? ☐ Y ☐ N
(applies to adults only; enter amount rec'd on a regular monthly basis; if children have income, add to Head of Household)

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)* ☐ Y ☐ N

SNAP	☐	TANF Transportation	☐		
WIC	☐	Other TANF Benefit	☐		
TANF Childcare	☐	Other Non-Cash Benefit	☐		

Covered by Health Insurance *(all clients)* ☐ Y ☐ N

Medicaid	☐	Obtained through COBRA	☐	Medicaid Plan:			
Medicare	☐	Private Pay Health Insurance	☐	Wellcare	☐	Humana Medical Plan	☐
SCHIP	☐	State Health Insurance for Adults	☐	Staywell	☐	United Healthcare	☐
VA Medical	☐	Indian Health Services Program	☐	Staywell for Kids	☐	Sunshine Health	☐
Employer Provided	☐	Other Health Insurance	☐	Medicaid Plan # :	______________		

Additional Family Members:

	Household Member #2	Household Member #3	Household Member #4	Household Member #5
Last Name				
First Name				
Middle Name *(optional)*				
Suffix *(optional)*				
Social Security Number				
Date of Birth				
Gender	☐M ☐F ☐Trans M-F ☐ Trans F-M ☐ Gender Non-Conforming	☐M ☐F ☐Trans M-F ☐ Trans F-M ☐ Gender Non-Conforming	☐M ☐F ☐Trans M-F ☐ Trans F-M ☐ Gender Non-Conforming	☐M ☐F ☐Trans M-F ☐ Trans F-M ☐ Gender Non-Conforming
Race	☐ W ☐ B/AA ☐Asian ☐ AI/NA ☐ NH/PI	☐ W ☐ B/AA ☐Asian ☐ AI/NA ☐ NH/PI	☐ W ☐ B/AA ☐Asian ☐ AI/NA ☐ NH/PI	☐ W ☐ B/AA ☐Asian ☐ AI/NA ☐ NH/PI
Ethnicity	☐Hispanic/Latino ☐Non-Hispanic/Latino	☐Hispanic/Latino ☐Non-Hispanic/Latino	☐Hispanic/Latino ☐Non-Hispanic/Latino	☐Hispanic/Latino ☐Non-Hispanic/Latino
Disabling Conditions	Physical Disability Y ☐ N☐ Long Term – Y ☐ N☐ Developmental Y ☐ N ☐ Long Term – Y ☐ N☐ Chronic Health Y ☐ N ☐ Long Term – Y ☐ N☐ HIV/AIDS Y ☐ N ☐ Long Term – Y ☐ N☐ Mental Health Y ☐ N ☐ Long Term – Y ☐ N☐ Drug ☐ Alcohol ☐ Both ☐ Long Term – Y ☐ N☐	Physical Disability Y ☐ N☐ Long Term – Y ☐ N☐ Developmental Y ☐ N ☐ Long Term – Y ☐ N☐ Chronic Health Y ☐ N ☐ Long Term – Y ☐ N☐ HIV/AIDS Y ☐ N ☐ Long Term – Y ☐ N☐ Mental Health Y ☐ N ☐ Long Term – Y ☐ N☐ Drug ☐ Alcohol ☐ Both ☐ Long Term – Y ☐ N☐	Physical Disability Y ☐ N☐ Long Term – Y ☐ N☐ Developmental Y ☐ N ☐ Long Term – Y ☐ N☐ Chronic Health Y ☐ N ☐ Long Term – Y ☐ N☐ HIV/AIDS Y ☐ N ☐ Long Term – Y ☐ N☐ Mental Health Y ☐ N ☐ Long Term – Y ☐ N☐ Drug ☐ Alcohol ☐ Both ☐ Long Term – Y ☐ N☐	Physical Disability Y ☐ N☐ Long Term – Y ☐ N☐ Developmental Y ☐ N ☐ Long Term – Y ☐ N☐ Chronic Health Y ☐ N ☐ Long Term – Y ☐ N☐ HIV/AIDS Y ☐ N ☐ Long Term – Y ☐ N☐ Mental Health Y ☐ N ☐ Long Term – Y ☐ N☐ Drug ☐ Alcohol ☐ Both ☐ Long Term – Y ☐ N☐
Income	☐ Y ☐ N $__________	☐ Y ☐ N $__________	☐ Y ☐ N $__________	☐ Y ☐ N $__________
Non-Cash Benefits	☐ Y ☐ N __________	☐ Y ☐ N __________	☐ Y ☐ N __________	☐ Y ☐ N __________
Health Insurance	☐ Y ☐ N __________	☐ Y ☐ N __________	☐ Y ☐ N __________	☐ Y ☐ N __________
Medicaid Plan & Plan #: ***See above for Plan names***				