**Logo, company name

Description automatically generatedINTAKE APPLICATION**

**Person Requiring Services**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full Name: |  |  |  | DOB: |  |
|  | *Last* | *First* | *M.I.* |  |  |

|  |  |  |
| --- | --- | --- |
| Address: |  |  |
|  | *Street Address* | *Apartment/Unit #* |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | *City* | *State* | *ZIP Code* |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone: |  | Email |  |

Children & Spouse ( include DOB) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Employed: Yes or No Hire Date:

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person completing Intake Application (If the same as above please skip this area)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full Name: |  |  |  | Date: |  |
|  | *Last* | *First* | *M.I.* |  |  |

Relationship to Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Phone: |  | Email |  |

Which services are needed:

* Shelter Period needed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Job Application Assistance
* Housing Application Assistance
* Transportation Services
* Food Assistance

Detailed summary of why services are needed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Check which of the following that applies and add required information:

* Applicant has court involvement: Name and contact information of Probation/Parole Officer
* Applicant has DFCS involvement: Name and contact information of caseworker.
* Applicant is in a Mental Health Program: Note Diagnosis & All Prescribed Medication:
* Applicant is participating in a rehab program: Name of contact information of rehab program:

**Consents**

I give consent for all person’s name and contact information added to this document to be contacted. I certify that the information that I have provided on this application are true and complete to the best of my knowledge. I understand that false or misleading information in my application may result in denial of financial assistance.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:** |  | **Date:** |  |