

**VETERANS HOUSING SUPPORT PROGRAM
INTAKE ASSESSMENT**

COMPLETE FORM AND SEND TO: info@veteranshousingsupport.org

First and foremost, THANK YOU FOR YOUR SERVICE.

I. BASIC IDENTIFYING INFORMATION

Full Name: _____ Phone Number: _____

Date of birth: _____ Email: _____

Referring shelter/agency:

Gender:
Female
Male
Other _____

Pronouns:

Please share your pronouns:

- She/her/hers
- He/him/his
- They/them/theirs
- No pronoun
- Not listed
- Other: _____

Marital Status:

- Married
- Widowed
- Divorced
- Separated
- Never married

Ethnicity:

- White
- African American
- Hispanic
- Asian American
- Pacific Islander/Hawaiian
- Native American
- Alaskan Native
- No response

II. MILITARY INFORMATION

| Military Service | | | Deployment Information |
|------------------------------|-----------------------|---------------------------|-------------------------------|
| Branch of Service | Deployment Start Date | Deployment End Date | Deployment Location: _____ |
| | | | Number of Deployments |
| | | | |
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| | | | |
| | | | |
| Wounded Injured __ Yes __ No | | Purple Heart __ Yes __ No | |

What services/benefits do you receive from

Health insurance:

- Yes, through an employer.
- Yes, through the U.S. Department of Veterans Affairs (VA)
- Yes, through (TRICARE)
- No, I do not currently have health insurance.

III. INCOME

Employment:

Is client employed? **Y** **N** If yes, where? _____

Is employment: **FT** **PT** Salary or Hourly Wage: \$_____/hour month year

How long has the client been working there? _____ 13) Has client held other jobs? **Y** **N**

If yes, please detail client's job history:

| Place of Employment | Job Title | Duration of Employment |
|---------------------|-----------|------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

What is the longest the client has held a job? _____

Is the client currently attending any kind of job training program? **Y** **N**

If yes, name school and type of training:

Income:

Does client receive Income Assistance? **Y** **N**

If yes, check types of assistance client is currently receiving:

- | | | |
|---------|----------------|------------------|
| 1. SSI | 4. Food stamps | 6. Child Support |
| 2. TANF | 5. Medicaid | |
| 3. WIC | 7. Other _____ | |

Please list other income (Child/Spousal Support, Retirement, Disability, Unemployment):

Do you have any dependents?

| Name | Relationship | Sex | Age | DOB |
|------|--------------|-----|-----|-----|
| | | | | |
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Does client have childcare? **Y N** Is childcare reliable? **Y N**
Does she get assistance from OFC? **Y N** Is OFC support sufficient to cover childcare? **Y N**
What amount is the client responsible for? \$ _____ weekly / monthly

Is there current CPS/Foster Care involvement? **Y N**
Is there past CPS/Foster Care involvement? **Y N**
If yes, name social worker and phone: _____
Please detail CPS/Foster Care involvement:

| 8-9) Type of Involvement | Date | Outcome |
|--------------------------|------|---------|
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IV. EDUCATION

What is the highest level of education the client has achieved? (Check one)

- 1. Obtained a Professional Degree
- 2. Graduated College
- 3. Graduated from Trade School
- 4. Some College
- 5. Graduated High School
- 6. Obtained a GED
- 7. Did not graduate High School/No GED
- 8. Other

Is client currently enrolled in any type of educational program (GED classes, college courses)? **Y N**
If yes, name school and type of education:

IV. Health/Mental Health:

*****NOT GETTING INTO DETAILS******

Any past or current medical considerations or concerns? **Y N**
Any past or current mental health considerations or conditions? **Y N**

If applicable, do any dependents have any past or current medical considerations or problems? **Y N**

If applicable, do any dependents have any past or current mental health considerations or problems? **Y N**

If yes, please detail (nature of medical condition, current treatment, monitoring physician, etc.):

| Name | Medical/ Mental Health Condition | Treatment/ Medication | Monitoring Physician and Phone Number |
|------|-------------------------------------|--------------------------|--|
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VI. SUBSTANCE ABUSE

Does client have any current or past substance abuse history/issues? **Y N**

Do client's dependents have any current or past substance abuse history/issues? **Y N**

| Name | Type of Problem | Treatment/ Medication | Treatment Program (Therapist and Phone) |
|------|-----------------|--------------------------|--|
| | | | |
| | | | |
| | | | |
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VII. COURT INVOLVEMENT

Are there any current or past criminal justice charges or involvement against the client? **Y N**

Are there any current or past criminal justice charges or involvement against client's dependents? **Y N**

Does client have any current or past civil or criminal court actions pending against others? **Y N**

Please describe:

| Type of Involvement | Date | Outcome |
|---------------------|------|---------|
| | | |
| | | |
| | | |

VIII. CITIZENSHIP STATUS

Are all family members U.S. Citizens? **Y N**

If no, please detail the nature of client's and dependents' immigrant status:

| Name | Legal Status | Action Needed |
|------|--------------|---------------|
| | | |
| | | |
| | | |

IX. TRANSPORTATION

Does the client have a car? Y N

Does client know how to use public transportation? Y N

X. SHELTER STAY

Most recent stay at Fairfax County Shelter:

Entry Date _____ Exit Date _____ Number of Days _____

Any previous stays? Y N If yes, please list:

Entry Date _____ Exit Date _____ Number of Days _____

Entry Date _____ Exit Date _____ Number of Days _____

XI. ABUSE

Is there a history of abuse?

Has the client been involved in other abusive relationships? Y N How many? _____

IF PRESENT ABUSE

What is the name, last known address, and brief description of abuser’s appearance (e.g. race, facial hair, age, color of hair and eyes, etc.):

Does the abuser know any of your passwords/have access to bank accounts, etc.? Please explain:

Is the abuser currently in treatment? Y N If yes, what program _____

Does the client have the desire for reunification? Y N If yes, explain

Does abuser have history of stalking? Y N if yes, describe _____

Does abuser possess weapons? Y N If yes, describe _____

Is abuser the father of the child(ren)? Y N

Does client have plans for children to have visitation? **Y N** If yes please explain _____

Does the client have a reliable support system (family, friends, church, other)? **Y N** Please describe:

Has client ever participated in other housing programs? **Y N**

Has client ever experienced an eviction? Y N

If yes, please give year and circumstances:

If accepted to the program, is the client interested in receiving Case Management services? Y N

Is client on any Subsidized Housing lists (Public Housing, Section 8, Private)? Y N

Name is on following lists:

Does the client have any furniture to take to the unit: _____

Any goals a client would like to accomplish while in the program?

- 1.
- 2.
- 3.
- 4.

Other Considerations: _____

Will you consent to a background check? Y N

If yes, please sign and date:

Signature: _____ Date: _____