FAMILIES FIRST OF MONROE COUNTY

Intake Form

www.familiesfirstofmonroecounty.org • Resources • Information • Referrals

APPLICANT NAME: (Last)________________________ (First)________________________ (MI)__________

HOUSEHOLD SIZE: ____________ NUMBER OF ADULTS: ____________ NUMBER OF CHILDREN: ____________

STREET ADDRESS: ____ CITY: ____________________

PHONE NUMBER: (________) __________ - __________ BIRTHDATE: ________ / ________ / __________

HAVE YOU RECEIVED SERVICES FROM FAMILIES FIRST BEFORE? ☐ YES ☐ NO IF SO, WHEN? ______________________

WHAT SERVICES? ☐ Rental Assistance ☐ Utility Assistance ☐ Other: ____________________

Are You Currently Fleeing Domestic Violence? ☐ YES ☐ NO

Is Anyone in the Household A Veteran? ☐ YES ☐ NO

Is Anyone in the Household Receiving Veteran Benefits? ☐ YES ☐ NO

Is Anyone in the Household Pregnant? ☐ YES ☐ NO

Is Anyone in the Household Under the Age Of 6? ☐ YES ☐ NO

Is Your Current/Future Residence Constructed After 1978? ☐ YES ☐ NO

Has Anyone in the Household Gone by Another Name? ☐ YES ☐ NO If Yes, Name: ______________________

PLEASE INDICATE HIGHEST LEVEL OF EDUCATION

☐ Some High School ☐ High School Diploma ☐ Some College ☐ Technical Degree

☐ College Degree 2 Year ☐ College Degree 4 Year ☐ Post Graduate Degree ☐ Other

PLEASE CHECK ALL BENEFITS RECEIVED BY ANY MEMBER OF THE HOUSEHOLD

☐ VA Medical ☐ Medicare ☐ Medicaid ☐ Badger Care (SCHIP)

☐ Private Pay Health Insurance ☐ COBRA ☐ State Insurance for Adults ☐ Employer Provided Health Insurance

☐ Section 8/Public Housing ☐ Temporary Rent Assistance ☐ Transportation Assistance ☐ WIC

☐ Child Care Assistance ☐ Food Share (SNAP) ☐ Other

DOES ANYONE IN YOUR HOUSEHOLD HAVE A DISABLING CONDITION LASTING SIX OR MORE MONTHS? ☐ YES ☐ NO

Name of Person: ________________________ What Condition(s)? ________________________

Diagnosed by Doctor/Therapist/AODA Counselor? ☐ YES ☐ NO SSA Determined? ☐ YES ☐ NO If Not, Is Application Pending? ☐ YES ☐ NO

Name of Person: ________________________ What Condition(s)? ________________________

Diagnosed by Doctor/Therapist/AODA Counselor? ☐ YES ☐ NO SSA Determined? ☐ YES ☐ NO If Not, Is Application Pending? ☐ YES ☐ NO

Name of Person: ________________________ What Condition(s)? ________________________

Diagnosed by Doctor/Therapist/AODA Counselor? ☐ YES ☐ NO SSA Determined? ☐ YES ☐ NO If Not, Is Application Pending? ☐ YES ☐ NO

Examples of Disabling Conditions

Alcohol Abuse	Chronic Health Condition	Developmental	Drug Abuse
HIV/AIDS	Mental Health Condition	Physical (Includes Mobility)	

HOUSEHOLD MEMBERS

First Name	Last Name	Relationship to HH	Gender	Date of Birth	Age	Race	Hispanic Y/N
		Head of Household					

LIVING SITUATION LAST NIGHT:

☐ Emergency Shelter, including hotel or motel paid for by a charitable organization

☐ Place not meant for human habitation

☐ Current rental with eviction notice

☐ None of the above (please explain) _____

IF YOU CHECKED EITHER EMERGENCY SHELTER OR PLACE NOT MEANT FOR HUMAN HABITATION, PLEASE COMPLETE THE FOLLOWING QUESTIONS:

Number of times you have been in a place not meant for human habitation, in an emergency shelter, on a motel voucher, or in a safe haven in the past three years including today _____

Number of months you have been in a place not meant for human habitation, in an emergency shelter, on a motel voucher, or in a safe haven in the past three years including today _____

Do you give consent that this agency may share information with other agencies such as, but not limited to your situation, household demographics, and any questions asked during this assessment for the purpose of providing a referral to the Coordinated Entry Prioritization Lists?

☐ Yes ☐ No ☐ Verbal

ACKNOWLEDGEMENT

I understand that the information contained in this application is provided voluntarily. The information is true and correct to the best of my knowledge. I am aware that providing false information or not reporting pertinent information is fraud. I also agree to notify the agency of any changes in income, family/household size, or address within 24 hours of such change. If I provide any false information, I understand the completion of this application does not guarantee that I will receive assistance.

_____ _____

Applicant Signature Date

_____ _____

Agency Rep Signature Date

HOUSEHOLD INCOME

Household Member	Source of Income	Start Date	Hourly Amount (Employment Only)	Hours per Week (Employment Only)	Monthly Gross	Yearly Gross (Office Staff Only)

TOTAL ANNUAL HOUSEHOLD INCOME: $_____

NO INCOME: Do you certify that you do not have any income from any source at this time? ☐Yes ☐No

_____ _____

Applicant Signature Date

_____ _____

Agency Rep Signature Date

Families First of Monroe County

Informed Consent
Release of Confidential Information

United Way Community Partner

www.familiesfirstofmonroecounty.org ○ Resources ○ Information ○ Referrals

Name of Client: _____ Date: _____

The purpose of the Client Informed Consent and Release of Confidential Information is to assist Families First staff in determining the services and supports necessary and appropriate for my situation by allowing them permission to share confidential information. Please read the following statements and authorization before signing.

- I understand this assistance is to facilitate obtaining resources to support my plan, goals, and related needs.
- I understand if I have a legal guardian, my guardian may sign or cancel this consent on my behalf.
- I understand this is my decision to sign or not. If I do sign, I can change my mind at any time and will need to make a written request to cancel this consent and submit the request to Families First for consideration.
- I understand services are **NOT** contingent upon or influenced by my decision to permit/deny this release.
- I understand the information and records disclosed pursuant to this consent are protected by State regulations § 51.03(2). In the case of my minor child(ren) pursuant to § 51.30(5)(b), I understand I am giving consent to Families First to share and coordinate their information/records.
- I understand by signing this consent this will allow for a more immediate response to meeting my unique needs and,
- That by coordinating with multiple service providers there is an elimination of duplicate services and a reduction for my need in completing unnecessary paperwork and the re-telling of my situation.

Each adult and/or child in the household receiving services will need to have their own consent form completed.

Name of Individual: _____ DOB: _____/_____/_____ Last 4 of SSN: _____
Purpose or need:_____
Specific Type of Information Released/Discussed:_____

Yes	No	Agency/Provider Name/Other	Yes	No	
☐	☐	Monroe Co. Law Enforcement Center	☐	☐	Coulee cap
☐	☐	Monroe Co. Health & Human Services	☐	☐	Brighter Tomorrows
☐	☐	Current/Perspective Landlord:	☐	☐	Flocks Guardian
☐	☐	Utility Assistance:	☐	☐	Other: _____
☐	☐	Other: _____	☐	☐	Other: _____
☐	☐	Other: _____			

By signing this form, I have read and understand the contents and agree that Families First may release and exchange information both verbally and written for the purposes of coordinating, managing, and executing services and programming on my behalf to support and improve the current situation I have requested assistance for.

_____ /_____
Client Signature/Legally Authorized Persons Signature Date

_____ /_____
Staff Signature Date

For office use only:
☐ Authorization expires as of ___/___/___
☐ Yes ☐ No Verbal Consent
Date of verbal consent: ___/___/____
Staff Initials: __

Updated JMM 7/16/2020