

Colorado Springs/El Paso County HOH and Adult CE Central Intake Form

Client Name (All clients): First: _____ Middle: _____ Last Name: _____

Name Data Quality (Agency Use Only)

- Full name reported Partial, street name, or code name reported Client doesn't know Client refused

Date of Birth (mm/dd/yyyy) (All clients): _____ / _____ / _____

DOB Data Quality (Agency Use Only)

- Full DOB reported Approximate or Partial DOB reported Client doesn't know Client refused

Social Security Number (All clients): _____

SSN Data Quality (Agency Use Only)

- Full SSN reported Approximate or Partial SSN reported Client doesn't know Client refused

Last Known Permanent Address (where you last lived for 90 days or more) (All clients):

Address _____

City: _____ County: _____ State: _____ Zip Code: _____

Address Data Quality (Agency Use Only)

- Full address reported Incomplete or estimated address Client doesn't know Client refused

Contact Information

Phone # _____ Phone Type Home Cell Work Message

Email address _____

Housing Status (All clients) (Agency Use Only)

- Category 1 - Homeless Category 2 - At imminent risk of losing housing Category 3 - Homeless only under other federal statutes
 Category 4 - Fleeing domestic violence At-risk of homelessness Stably housed
 Client doesn't know Client refused

Family Type (During program enrollment)

- Unaccompanied Single Parent (At least one adult and one minor – relation or non relation) Two Parents (At least two adults and one minor– relation or non relation)
 Adults Only Other: non-relation member

Relationship to Head of Household (All clients)

- Self (Head of Household) Head of Household's child Head of Household's spouse or partner
 Head of Household's other relation member Other: non-relation member

Gender: (All clients)

- Female Male Transgender M to F Transgender F to M Other Client doesn't know Client refused

Do you have a Disabling Condition? (All clients)

- Yes No Client doesn't know Client refused

Are you a Veteran? Have you Served/Serving in the U.S. Military: (Adults Only)

- Yes No Client doesn't know Client refused

Ethnicity (all clients)

- Non-Hispanic/Non-Latino Hispanic/Latino Client doesn't know Client refused

Race – check all that apply, but at least one: (All clients)

- American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White Client doesn't know Client refused

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Income and Sources

Income from any source	<input type="checkbox"/> No Financial Resources <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
<i>(If yes, indicate all sources and dollar amounts for the sources that apply)</i>	
Earned Income (employment income) (if yes) monthly amount	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____
Unemployment Insurance (if yes) monthly amount	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____
Supplemental Security Income (SSI) (if yes) monthly amount	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____
Social Security Disability Income (SSDI) (if yes) monthly amount	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____
VA Service-Connected Disability Compensation (if yes) monthly amount	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____
VA Non-Service-Connected Disability Pension (if yes) monthly amount	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____
Private Disability Insurance (if yes) monthly amount	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____
Worker's Compensation (if yes) monthly amount	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____
Temporary Assistance for Needy Families (TANF) (if yes) monthly amount	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____
General Assistance (GA) (if yes) monthly amount	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____
Retirement Income from Social Security (if yes) monthly amount	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____
Pension or Retirement Income from a former job (if yes) monthly amount	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____
Child Support (if yes) monthly amount	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____
Alimony or other spousal support (if yes) monthly amount	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____
Other source (if yes) monthly amount	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____
(if other source) Specify source	_____
Total Monthly Income	\$ _____

Non-Cash benefits (Head of household and adults)

Non-Cash benefit from any source?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
<i>(If yes, indicate all sources that apply)</i>	
<input type="checkbox"/> Food Stamp or Benefits Card and Amount \$ _____ <input type="checkbox"/> TANF Child Care services <input type="checkbox"/> TANF transportation services <input type="checkbox"/> Section 8, public housing, or other ongoing rental assistance <input type="checkbox"/> Temporary rental assistance. If yes, specify source _____	<input type="checkbox"/> Special Supplement Nutrition Program for Women, Infants, Children (WIC) <input type="checkbox"/> Other TANF-funded services <input type="checkbox"/> Other source _____

Health Insurance (All clients)

Covered by Health Insurance?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	
<i>(If yes, indicate all sources that apply)</i>		
<input type="checkbox"/> Medicaid <input type="checkbox"/> Veteran's Administration (VA) Medical Services <input type="checkbox"/> Private Pay Health Insurance	<input type="checkbox"/> Medicare <input type="checkbox"/> Employer-Provided Health Insurance <input type="checkbox"/> State Health Insurance for Adults	<input type="checkbox"/> State Children's Health Insurance <input type="checkbox"/> Health Insurance obtained through COBRA