

COMMUNITY RESPONSE/CONNECTED YOUTH INITIATIVE INTAKE FORM



For office use only:

NMIS#: _____

Entered into Clarity: _____

TODAY'S DATE: _____

SECTION I-a: Participant/Client Information

| | | | |
|---|--|---|---|
| Full Legal Name (first, middle, last)*: | | | |
| Maiden/Alias: | | Suffix (Jr, III): | Preferred Name: |
| Street Address: | | | |
| City: | | State: | Zip: |
| County*: | | Email: | |
| Home or Cell Phone #: | | | Date of Birth*: |
| Last 4 digits of Social Security Number: | | <input type="checkbox"/> Prefer Not to Answer | |
| What is your Gender?* | <input type="checkbox"/> Women (Female) | <input type="checkbox"/> Another Gender: | |
| | <input type="checkbox"/> Man (Male) | <input type="checkbox"/> Trans Female (MTF or Male to Female) | |
| | <input type="checkbox"/> I don't know | <input type="checkbox"/> Trans Male (FTM or Female to Male) | |
| | <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Gender Non-Conforming (not exclusively male or female) | |
| Race (Select up to 2): | <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | |
| | <input type="checkbox"/> Asian | <input type="checkbox"/> I don't know | |
| | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Prefer not to answer | |
| | <input type="checkbox"/> White | | |
| Ethnicity: | <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> White | |
| | <input type="checkbox"/> Asian | <input type="checkbox"/> I don't know | |
| | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Prefer not to answer | |
| | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | | |
| U.S. Military Veteran | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer |
| Do you have a disabling condition? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer |

Answer 'Yes' or 'No' for each disability type (in white).
 If the client selects 'Yes' for any disability type, you must also complete the shaded sections below.

| Disability Type | Yes | No | Is your disability expected to be long-term and indefinite duration or substantially impairs your ability to live independently? | | | |
|--------------------------|--------------------------|--------------------------|--|-----------------------------|---------------------------------------|---|
| Alcohol Abuse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know | <input type="checkbox"/> Prefer not to answer |
| Drug Abuse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know | <input type="checkbox"/> Prefer not to answer |
| Developmental Disability | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know | <input type="checkbox"/> Prefer not to answer |
| HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know | <input type="checkbox"/> Prefer not to answer |
| Mental Health Problem | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know | <input type="checkbox"/> Prefer not to answer |
| Physical Disability | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know | <input type="checkbox"/> Prefer not to answer |
| Chronic Health Condition | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know | <input type="checkbox"/> Prefer not to answer |

| | | |
|---|------------------------------|---|
| Are you currently covered by Health Insurance? | <input type="checkbox"/> Yes | <input type="checkbox"/> I don't know |
| | <input type="checkbox"/> No | <input type="checkbox"/> Prefer not to answer |

Answer 'Yes' or 'No' for each health insurance source. Answer 'Yes' for any source that is currently received. Answer 'No' for sources that have been terminated, even if they were received in the past. If the client selects 'Yes' for any insurance type, complete the shaded section below.

| Health Insurance Type | Yes | No | Health Insurance Type | Yes | No |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| Medicaid | <input type="checkbox"/> | <input type="checkbox"/> | Health Insurance obtained through COBRA | <input type="checkbox"/> | <input type="checkbox"/> |
| Medicare | <input type="checkbox"/> | <input type="checkbox"/> | Private Pay Health Insurance | <input type="checkbox"/> | <input type="checkbox"/> |
| State Children's Health Insurance Program | <input type="checkbox"/> | <input type="checkbox"/> | State Health Insurance for Adults | <input type="checkbox"/> | <input type="checkbox"/> |
| Veteran's Administration (VA) Medical Services | <input type="checkbox"/> | <input type="checkbox"/> | Indian Health Services Program | <input type="checkbox"/> | <input type="checkbox"/> |
| Employer-Provided Health Insurance | <input type="checkbox"/> | <input type="checkbox"/> | Other (specify): | <input type="checkbox"/> | <input type="checkbox"/> |

| | | |
|--|------------------------------|---|
| As a child were you ever in Foster Care or are you now? | <input type="checkbox"/> Yes | <input type="checkbox"/> I don't know |
| | <input type="checkbox"/> No | <input type="checkbox"/> Prefer not to answer |

If YES, number of years:

Less than 1 year – Enter number of months: ___ 1 – 2 years 3 – 5 or more years Prefer not to answer

If YES, how long ago did you exit Foster Care?

90 days 6 months 9 months 12 months More than 12 months

| | | |
|--|---|---|
| If you are between the ages of 14 to 25 have you experienced the following? | <input type="checkbox"/> In-home services for your family (from DHHS) | <input type="checkbox"/> Homelessness |
| | <input type="checkbox"/> Guardianship or Adoption | <input type="checkbox"/> Human Trafficking |
| | <input type="checkbox"/> Probation or Incarceration | <input type="checkbox"/> Prefer not to answer |
| | | <input type="checkbox"/> N/A, no experience with any of these |

| | | |
|---|------------------------------|---|
| Are you a domestic violence victim/survivor? | <input type="checkbox"/> Yes | <input type="checkbox"/> I don't know |
| | <input type="checkbox"/> No | <input type="checkbox"/> Prefer not to answer |

If YES, when did the experience occur?

Within the past three months Three to six months ago From seven to twelve months ago

More than a year ago Client does not know Prefer not to answer

→If YES, Is the client currently fleeing?

Yes No Client doesn't know Client refused Data not collected

| | | | | |
|---------------------------|---------------------------------------|---|---------------------------------------|---|
| Sexual Orientation | <input type="checkbox"/> Heterosexual | <input type="checkbox"/> Gay | <input type="checkbox"/> Lesbian | <input type="checkbox"/> Bisexual |
| | <input type="checkbox"/> Other | <input type="checkbox"/> Questioning/Unsure | <input type="checkbox"/> I don't know | <input type="checkbox"/> Prefer not to answer |

| | | | | |
|---|------------------------------|-----------------------------|---------------------------------------|---|
| Are you currently pregnant or expecting a child? (Mother or Father)* | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know | <input type="checkbox"/> Prefer not to answer |
|---|------------------------------|-----------------------------|---------------------------------------|---|

If pregnant, projected date of birth?

Month: / Date: / Year:

| | | | | |
|--|---|---|--|--|
| What is your Highest level of education attained? | <input type="checkbox"/> No schooling completed | <input type="checkbox"/> 9 th grade | <input type="checkbox"/> High School diploma | <input type="checkbox"/> Post-Secondary School |
| | <input type="checkbox"/> Nursery School - 4th grade | <input type="checkbox"/> 10 th grade | <input type="checkbox"/> I don't know | <input type="checkbox"/> Prefer not to answer |
| | <input type="checkbox"/> 5th grade or 6th grade | <input type="checkbox"/> 11 th grade | | |
| | <input type="checkbox"/> 7th grade or 8th grade | <input type="checkbox"/> 12 th grade, no diploma | | |
| | | | | |

SECTION I-b: Adult #2 in Household

| | | |
|-------------|--------------|------------|
| First Name: | Middle Name: | Last Name: |
|-------------|--------------|------------|

| | | |
|---------------|-------------------|-----------------|
| Maiden/Alias: | Suffix (Jr, III): | Preferred Name: |
|---------------|-------------------|-----------------|

| | | |
|--------|----------|----------------|
| Email: | Phone #: | Date of Birth: |
|--------|----------|----------------|

| | |
|---|---|
| Last 4 digits of Social Security Number: | <input type="checkbox"/> Prefer Not to Answer |
|---|---|

| | | |
|-------------------------------|---|---|
| What is your Gender?:* | <input type="checkbox"/> Women (Female) | <input type="checkbox"/> Another Gender: |
| | <input type="checkbox"/> Man (Male) | <input type="checkbox"/> Trans Female (MTF or Male to Female) |
| | <input type="checkbox"/> I don't know | <input type="checkbox"/> Trans Male (FTM or Female to Male) |
| | <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Gender Non-Conforming (not exclusively male or female) |
| | | |

| | | |
|-------------------------------|---|--|
| Race (Select up to 2): | <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| | <input type="checkbox"/> Asian | <input type="checkbox"/> I don't know |
| | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Prefer not to answer |
| | <input type="checkbox"/> White | |
| | | |

| | | |
|-------------------|--|---|
| Ethnicity: | <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> White |
| | <input type="checkbox"/> Asian | <input type="checkbox"/> I don't know |
| | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Prefer not to answer |
| | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | |
| | | |

| | | | | |
|------------------------------|------------------------------|-----------------------------|---------------------------------------|---|
| U.S. Military Veteran | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know | <input type="checkbox"/> Prefer not to answer |
|------------------------------|------------------------------|-----------------------------|---------------------------------------|---|

| | | | | |
|---|------------------------------|-----------------------------|---------------------------------------|---|
| Do you have a disabling condition? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know | <input type="checkbox"/> Prefer not to answer |
|---|------------------------------|-----------------------------|---------------------------------------|---|

Answer 'Yes' or 'No' for each disability type (in white).
If the client selects 'Yes' for any disability type, you must also complete the shaded sections below.

| Disability Type | Yes | No | Is your disability expected to be long-term and indefinite duration or substantially impairs your ability to live independently? | | | |
|-----------------|--------------------------|--------------------------|--|-----------------------------|---------------------------------------|---|
| Alcohol Abuse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know | <input type="checkbox"/> Prefer not to answer |
| Drug Abuse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know | <input type="checkbox"/> Prefer not to answer |

| | | | | | | |
|--------------------------|--------------------------|--------------------------|------------------------------|-----------------------------|---------------------------------------|---|
| Developmental Disability | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know | <input type="checkbox"/> Prefer not to answer |
| HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know | <input type="checkbox"/> Prefer not to answer |
| Mental Health Problem | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know | <input type="checkbox"/> Prefer not to answer |
| Physical Disability | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know | <input type="checkbox"/> Prefer not to answer |
| Chronic Health Condition | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know | <input type="checkbox"/> Prefer not to answer |

Are you currently covered by Health Insurance? Yes I don't know
 No Prefer not to answer

Answer 'Yes' or 'No' for each health insurance source. Answer 'Yes' for any source that is currently received. Answer 'No' for sources that have been terminated, even if they were received in the past. If the client selects 'Yes' for any insurance type, complete the shaded section below.

| Health Insurance Type | Yes | No | Health Insurance Type | Yes | No |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| Medicaid | <input type="checkbox"/> | <input type="checkbox"/> | Health Insurance obtained through COBRA | <input type="checkbox"/> | <input type="checkbox"/> |
| Medicare | <input type="checkbox"/> | <input type="checkbox"/> | Private Pay Health Insurance | <input type="checkbox"/> | <input type="checkbox"/> |
| State Children's Health Insurance Program | <input type="checkbox"/> | <input type="checkbox"/> | State Health Insurance for Adults | <input type="checkbox"/> | <input type="checkbox"/> |
| Veteran's Administration (VA) Medical Services | <input type="checkbox"/> | <input type="checkbox"/> | Indian Health Services Program | <input type="checkbox"/> | <input type="checkbox"/> |
| Employer-Provided Health Insurance | <input type="checkbox"/> | <input type="checkbox"/> | Other (specify): | <input type="checkbox"/> | <input type="checkbox"/> |

As a child were you ever in Foster Care or are you now? Yes I don't know
 No Prefer not to answer

If YES, number of years:
 Less than 1 year –Enter number of months:___ 1 – 2 years 3 – 5 or more years Prefer not to answer

If YES, how long ago did you exit Foster Care?
 90 days 6 months 9 months 12 months More than 12 months

If you are between the ages of 14 to 25 have you experienced the following?
 In-home services for your family (from DHHS) Homelessness
 Guardianship or Adoption Human Trafficking
 Probation or Incarceration Prefer not to answer
 N/A, no experience with any of these

Are you a domestic violence victim/survivor? Yes I don't know
 No Prefer not to answer

If YES, when did the experience occur?
 Within the past three months Three to six months ago From seven to twelve months ago
 More than a year ago Client does not know Prefer not to answer

If YES, Is the client currently fleeing?
 Yes No Client doesn't know Client refused Data not collected

Sexual Orientation Heterosexual Gay Lesbian Bisexual
 Other Questioning/Unsure I don't know Prefer not to answer

Are you currently pregnant or expecting a child? (Mother or Father)* Yes No I don't know Prefer not to answer

If pregnant, projected date of birth? _____ / _____ / _____
Month Date Year

What is your Highest level of education attained?
 No schooling completed 9th grade High School diploma Post-Secondary School
 Nursery School - 4th grade 10th grade I don't know Prefer not to answer
 5th grade or 6th grade 11th grade
 7th grade or 8th grade 12th grade, no diploma

SECTION II: Household Information

Household Relationship Information
 Blended Single Female Parent
 Couple with No Children Single Male Parent
 Couple (Parent & Friend) w/ child(ren) Single Person
 Non-Custodial Caregiver(s) Two Parent Family
 Foster Parent(s) Other
 Grandparent(s) and Child(ren)

Housing Status
 Category 1 – Homeless At-risk of homelessness
 Category 2 – At imminent risk of losing housing Stably housed
 Category 3 – Homeless under other Federal Statues I do not know
 Category 4 – Fleeing violence Prefer not to answer

| | | | |
|---|---|--|--|
| Zip Code of last permanent address | | | |
| Including yourself, how many adults (people 18+) are in your household?* | | | |
| How many CHILDREN (people 17 and younger) are in your household? Enter 0 if no children live with you.* | | | |
| Do any of your children have a disability?* | <input type="checkbox"/> Yes, how many _____ <input type="checkbox"/> No | <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | |
| Do you have full custody of your child/children? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | |
| Do you have an open or voluntary case with the Child Protective Services/ DHHS? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | |

SECTION III: Assistance Request

You will be asked to provide documentation for certain needs such as rent support or unpaid bills, so please bring them with you if you can. Examples include: Shut off notices from utility companies, eviction notices, unpaid medical bills, estimate of health services, childcare assistance, etc.

| | |
|---|---|
| What is your most urgent need? About how much does it cost? Please include as much detail as possible. | |
| Check all that apply: <input type="checkbox"/> Child Care Assistance <input type="checkbox"/> Daily living (tel., clothes, hygiene) <input type="checkbox"/> Dentist <input type="checkbox"/> Education <input type="checkbox"/> Employment <input type="checkbox"/> Finances <input type="checkbox"/> General Life Skills <input type="checkbox"/> Housing <input type="checkbox"/> Legal Help <input type="checkbox"/> Mental Health <input type="checkbox"/> Parenting Assistance <input type="checkbox"/> Physical Health <input type="checkbox"/> Substance Use <input type="checkbox"/> Supportive Relationships <input type="checkbox"/> Transportation <input type="checkbox"/> Utilities <input type="checkbox"/> Other: _____ | Explain your need in as much detail as possible with cost information: |

| | | | |
|--------------------------------------|---------------|----------|------|
| Where should we send payment? | | | |
| Business Name: | Contact Name: | Phone #: | |
| Street Address: | City: | State: | Zip: |

| | | | |
|--|-----------------------------|---------------------------------|--|
| Have you been financially impacted by COVID-19? | | | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure | <input type="checkbox"/> Prefer not to say |
| <i>If yes, please explain:</i> | | | |

| | | | |
|--|-----------------------------|---------------------------------|--|
| Do you or your children QUALIFY for Medicaid, Title XX, and/or free and reduced lunch, even if you don't receive any of them? * | | | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure | <input type="checkbox"/> Prefer not to say |
| Is there someone who doesn't live with you we can contact if we can't reach you? | | | |
| <input type="checkbox"/> Yes, please list below: | <input type="checkbox"/> No | <input type="checkbox"/> Unsure | <input type="checkbox"/> Prefer not to say |
| Name: | Phone: | | |
| Relationship to you (ex. friend, foster parent, etc): | | | |
| Do you have enough people to count on when you need someone to give you good advice?* | | | |
| <input type="checkbox"/> Yes, how many? (write in number) | <input type="checkbox"/> No | <input type="checkbox"/> Unsure | <input type="checkbox"/> Prefer not to say |

| SECTION IV: Child/Children Intake Form | | | | | |
|--|---|---|---|---|---|
| | CHILD #1 | CHILD #2 | CHILD #3 | CHILD #4 | CHILD #5 |
| Last Name | | | | | |
| First Name | | | | | |
| Last 4 Digits of SSN | | | | | |
| Date of Birth | | | | | |
| Gender | <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans Female (MTF or Male to Female) <input type="checkbox"/> Trans Male (FTM or Female to Male) <input type="checkbox"/> Gender Non-Conforming (not exclusively male or female) <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans Female (MTF or Male to Female) <input type="checkbox"/> Trans Male (FTM or Female to Male) <input type="checkbox"/> Gender Non-Conforming (not exclusively male or female) <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans Female (MTF or Male to Female) <input type="checkbox"/> Trans Male (FTM or Female to Male) <input type="checkbox"/> Gender Non-Conforming (not exclusively male or female) <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans Female (MTF or Male to Female) <input type="checkbox"/> Trans Male (FTM or Female to Male) <input type="checkbox"/> Gender Non-Conforming (not exclusively male or female) <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans Female (MTF or Male to Female) <input type="checkbox"/> Trans Male (FTM or Female to Male) <input type="checkbox"/> Gender Non-Conforming (not exclusively male or female) <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer |
| Race | <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer |
| Ethnicity | <input type="checkbox"/> Non-Hispanic / Non-Latino <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Non-Hispanic / Non-Latino <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Non-Hispanic / Non-Latino <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Non-Hispanic / Non-Latino <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Non-Hispanic / Non-Latino <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer |
| Disabling Condition | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer |

| | | | | | |
|--|--|--|--|--|--|
| Type of Disabling Condition (check all the apply if YES is marked on the previous question Disabling Condition) | <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Developmental Disability <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problem <input type="checkbox"/> Physical Disability <input type="checkbox"/> Chronic Health Condition | <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Developmental Disability <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problem <input type="checkbox"/> Physical Disability <input type="checkbox"/> Chronic Health Condition | <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Developmental Disability <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problem <input type="checkbox"/> Physical Disability <input type="checkbox"/> Chronic Health Condition | <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Developmental Disability <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problem <input type="checkbox"/> Physical Disability <input type="checkbox"/> Chronic Health Condition | <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Developmental Disability <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problem <input type="checkbox"/> Physical Disability <input type="checkbox"/> Chronic Health Condition |
| Relationship to Participant/ Client | <input type="checkbox"/> Head of household's child <input type="checkbox"/> Head of household's spouse or partner <input type="checkbox"/> Head of household's other relation member <input type="checkbox"/> (other relation to head of household) <input type="checkbox"/> Other: non-relation member <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Head of household's child <input type="checkbox"/> Head of household's spouse or partner <input type="checkbox"/> Head of household's other relation member <input type="checkbox"/> (other relation to head of household) <input type="checkbox"/> Other: non-relation member <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Head of household's child <input type="checkbox"/> Head of household's spouse or partner <input type="checkbox"/> Head of household's other relation member <input type="checkbox"/> (other relation to head of household) <input type="checkbox"/> Other: non-relation member <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Head of household's child <input type="checkbox"/> Head of household's spouse or partner <input type="checkbox"/> Head of household's other relation member <input type="checkbox"/> (other relation to head of household) <input type="checkbox"/> Other: non-relation member <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Head of household's child <input type="checkbox"/> Head of household's spouse or partner <input type="checkbox"/> Head of household's other relation member <input type="checkbox"/> (other relation to head of household) <input type="checkbox"/> Other: non-relation member <input type="checkbox"/> Prefer not to answer |
| Covered by Insurance | <input type="checkbox"/> Yes (check all that apply below) <input type="checkbox"/> No <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Yes (check all that apply below) <input type="checkbox"/> No <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Yes (check all that apply below) <input type="checkbox"/> No <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Yes (check all that apply below) <input type="checkbox"/> No <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Yes (check all that apply below) <input type="checkbox"/> No <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer |
| Health Insurance (check all the apply if YES is marked on the question "Covered by Insurance") | <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> CHIP <input type="checkbox"/> Veteran's Affairs <input type="checkbox"/> Head of household's employer <input type="checkbox"/> Head of household's COBRA <input type="checkbox"/> Private Pay <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> CHIP <input type="checkbox"/> Veteran's Affairs <input type="checkbox"/> Head of household's employer <input type="checkbox"/> Head of household's COBRA <input type="checkbox"/> Private Pay <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> CHIP <input type="checkbox"/> Veteran's Affairs <input type="checkbox"/> Head of household's employer <input type="checkbox"/> Head of household's COBRA <input type="checkbox"/> Private Pay <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> CHIP <input type="checkbox"/> Veteran's Affairs <input type="checkbox"/> Head of household's employer <input type="checkbox"/> Head of household's COBRA <input type="checkbox"/> Private Pay <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> CHIP <input type="checkbox"/> Veteran's Affairs <input type="checkbox"/> Head of household's employer <input type="checkbox"/> Head of household's COBRA <input type="checkbox"/> Private Pay <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Other: _____ |

OPTIONAL - Section V: Childcare Information

This section needs to ONLY be completed if you are in need of childcare assistance.

| | | | |
|-----------------------------|--|--|--|
| Name of Childcare Provider: | | Average Weekly Childcare Cost: | |
| Childcare Provider Phone #: | | Average number of hours per week your child/children attend childcare: | |
| Childcare Provider Address: | | | |

SECTION VI: Household Income and Expenses Information

| | Participant/Client | | Adult #2 | |
|--|------------------------------|---|------------------------------|---|
| Employer | | | | |
| Hourly Wage | | | | |
| Hours of Work per Week | | | | |
| Are you out of work because of COVID-19? | <input type="checkbox"/> Yes | <input type="checkbox"/> I don't know | <input type="checkbox"/> Yes | <input type="checkbox"/> I don't know |
| | <input type="checkbox"/> No | <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> No | <input type="checkbox"/> Prefer not to answer |
| Have you applied for Unemployment? | <input type="checkbox"/> Yes | <input type="checkbox"/> I don't know | <input type="checkbox"/> Yes | <input type="checkbox"/> I don't know |
| | <input type="checkbox"/> No | <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> No | <input type="checkbox"/> Prefer not to answer |

| Source of Income | Yes | No | If yes, monthly amount from source: |
|--|-----|----|-------------------------------------|
| Earned Income (from job) | | | \$ |
| Unemployment | | | \$ |
| SSI - Supplemental Security Income | | | \$ |
| SSDI - Social Security Disability Income | | | \$ |
| VA Service Connected Disability Compensation | | | \$ |
| VA Non-Service Connected Disability Pension | | | \$ |
| Private Disability Insurance | | | \$ |
| Worker's Compensation | | | \$ |
| TANF - Temporary Assistance for Needy Families | | | \$ |
| General Assistance (GA) | | | \$ |
| SSA - Social Security | | | \$ |
| Pension/Retirement Income from Former Job | | | \$ |
| Child Support | | | \$ |
| Alimony or Other Spousal Support | | | \$ |
| Contributions from Other People | | | \$ |
| Aid to Dependent Care (ADC) | | | \$ |
| Other (specify): | | | \$ |
| TOTAL MONTHLY INCOME FROM ALL SOURCES: | | | \$ |

PUBLIC BENEFITS – Do you have any non-cash benefits from any source?

| Source of Public Benefit | Yes | No | If yes, monthly amount from source |
|--|-----|----|------------------------------------|
| Housing Voucher/Section 8 | | | \$ |
| LIHEAP - <i>Low Income Home Energy Program</i> | | | \$ |
| SNAP - <i>Supplemental Nutrition Assistance Program</i> | | | \$ |
| WIC - <i>Special Supplemental Nutrition Program for Women, Infants, and Children</i> | | | \$ |
| TANF Child Care Services | | | \$ |
| TANF Transportation Services | | | \$ |
| Other TANF-funded Services | | | \$ |
| Other (specify): | | | \$ |
| TOTAL NON-CASH BENEFIT: | | | \$ |

CURRENT MONTHLY LIVING EXPENSES

| Expense Category | Amount of Expense | Expense Category | Amount of Expense |
|------------------------------------|--------------------------|---------------------------|--------------------------|
| SAVINGS | | FAMILY | |
| Emergency Plan | | Life Insurance | |
| HOUSING | | Childcare | |
| Rent/Mortgage | | Allowance/Spending Money | |
| 2nd Mortgage/Mobile Home Space | | Alimony/Child Support | |
| Property Tax | | EDUCATION | |
| Renters/Homeowners Ins | | Tuition/School Expense | |
| Home Furnishings (ex. rent to own) | | Music or Other Lessons | |
| Repairs & Improvements | | Student Loans | |
| UTILITIES | | ENTERTAINMENT | |
| Electricity/Water | | Movie Rentals/Netflix | |
| Gas | | Dining Out | |
| Trash | | Sports/Hobbies | |
| FOOD | | Vacations | |
| Groceries | | Lottery/Gambling | |
| Food Bought at Work | | | |
| School Lunches | | PERSONAL | |
| TRANSPORTATION | | Hair Cut/Nails | |
| Car Payment #1 | | Toiletries/Cosmetics | |
| Car Payment #2 | | Tobacco/Alcohol/Drugs | |
| Gasoline | | BUNDLED SERVICES | |
| Auto Insurance | | Phone | |
| Maintenance/Tires | | Cable/Satellite | |
| Parking/Carpool | | Internet | |
| CLOTHING | | MISC | |
| For Family | | Pet Care | |
| Laundry | | Other Debts/Garnishments | |
| HEALTH CARE | | | |
| Health Insurance** | | TOTAL EXPENSES | |
| Doctor/Dentist/Eye Care | | TOTAL INCOME | |
| Prescriptions | | | |
| Other | | NET MONTHLY INCOME | |

SECTION VII: CR/CYI Participant Information Survey

INSTRUCTIONS: All parts of the Participant Information Survey should be completed at the start of participation in Community Response or the Connected Youth Initiative. The form may be completed with the assistance of a Central Navigator or other service provider, if needed.

| | | |
|---|-------------------------------------|------------------------------------|
| I agree to have my information shared for the Evaluation below: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| As part of the evaluation of Community Response and the Connected Youth Initiative, your data will be shared with Nebraska Children and their evaluators from Munroe-Meyer Institute. Your name will not be included in any of the information that is provided to the evaluation team. All data is summarized as a group. You can choose not to participate in the evaluation. If you have questions please call Dr. Barbara Jackson at 402-559-5765 | | |
| Participant Signature: | Date: | |

For each of the following, mark the response that most closely matches how you feel.

| SOCIAL CONNECTIONS | A. NOT AT ALL LIKE MY LIFE | B. NOT MUCH LIKE MY LIFE | C. SOMEWHAT LIKE MY LIFE | D. QUITE A LOT LIKE MY LIFE | E. JUST LIKE MY LIFE | N/A I DO NOT HAVE KIDS |
|---|---|-----------------------------|---|--------------------------------|-------------------------|---------------------------|
| I have people who believe in me. | | | | | | |
| I have someone in my life who gives me advice, even when it's hard to hear. | | | | | | |
| When I am trying to work on achieving a goal, I have friends who will support me. | | | | | | |
| When I need someone to look after my kids on short notice, I can find someone I trust | | | | | | |
| I have people I trust to ask for advice about (check all that apply) | <input type="checkbox"/> Money/Bills/Budgeting <input type="checkbox"/> Relationships and/or my love life <input type="checkbox"/> Food/Nutrition | | <input type="checkbox"/> Stress, Anxiety, and/or Depression <input type="checkbox"/> Parenting/My kids (if applicable) <input type="checkbox"/> None of the above | | | |

| CONCRETE SUPPORTS | A. NOT AT ALL LIKE MY LIFE | B. NOT MUCH LIKE MY LIFE | C. SOMEWHAT LIKE MY LIFE | D. QUITE A LOT LIKE MY LIFE | E. JUST LIKE MY LIFE |
|---|-------------------------------|-----------------------------|-----------------------------|--------------------------------|-------------------------|
| I was able to cover all my expenses last month (<i>expenses include costs like rent, utility bills, food, transportation, child care, and medical expenses</i>) | | | | | |
| The transportation I use is reliable and consistent | | | | | |
| My housing situation is affordable, safe, and stable | | | | | |
| Over the past three months, my children and I have been able to see a doctor when we needed to. (<i>If you do not have children, answer for just yourself</i>) | | | | | |
| Over the past three months, I have found a job and/or worked when I needed to | | | | | |

| |
|--------------|
| NMIS#: _____ |
|--------------|

I _____ understand information about me and/or my dependents listed in this application is entered into a database system called Clarity Human Services. This system helps to better understand homelessness, to improve service delivery, and to evaluate the effectiveness of services provided. Participation in data collection is a critical component of our community’s ability to provide the most effective services and housing possible. The information that is collected is protected by limiting access to the database and limiting what information may be shared. Access to the data and sharing of the data is in compliance with the standards set by the federal, state, and local regulations governing confidentiality of client records. Every person and agency that is authorized to read or enter information into the system has signed an agreement to maintain the security and confidentiality of the information.

By signing this form, I authorize the following:

The information collected by this agency will be included in Clarity Human Services and only partner agencies, which have entered into an HMIS Agency Participation Agreement, may use it to:

- Produce a client profile at intake that will be shared with collaborating agencies
- Produce aggregate level reports regarding use of services
- Track individual program-level outcomes
- Identify unfilled service needs and plan for enhancements
- Allocate resources among agencies engaged in services
- Share information from the CR/CYI evaluation

By signing this form, I authorize the following:

I authorize the partner agencies and their representatives to share basic information regarding my family members listed below and/or me. I understand that this information is for the purpose of assessing my/our needs for housing, utility assistance, food, counseling, and/or other services.

Additionally, the United Way of South Central Nebraska Response System, its partners and community assistance organizations to communicate with and disclose to one another in verbal, written, electronic or facsimile in regard to services that are provided to me and my family on an as needed basis only. The purpose of disclosing basic information such as name and type/amount of assistance provided is to better coordinate services for the family and make the best use of limited community resources.

The information may consist of the following PPI (Personal Protected Information):

- | | | |
|---------------------------|------------------------------------|--------------------------|
| ● Housing information | ● Residence Prior to Project Entry | ● Disabling Condition |
| ● Name | ● Gender | ● Homeless History |
| ● Date of Birth | ● Social Security Number | ● Photo (if applicable) |
| ● Family Composition | ● Ethnicity and Race | ● Domestic Violence |
| ● Health Insurance Status | ● Client Location | ● Program Entry and Exit |
| ● Income/Non-cash | ● Veteran Status | ● Assessments |
| ● VI-SPDAT | ● Services Provided | |

I Understand That:

- ✓ The partner agencies have signed agreements to treat my information in a professional and confidential manner. I have the right to view the client confidentiality policies used by the HMIS partner agencies.
- ✓ Staff members of the partner agencies who will see my information have signed agreements to maintain confidentiality regarding my information.
- ✓ The release of my information does not guarantee that I will receive assistance; my refusal to authorize the use of my information does not disqualify me from receiving assistance.
- ✓ My records are protected by federal, state, and local regulations governing confidentiality of client records and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- ✓ This authorization will remain in effect until I revoke it in writing, and I may revoke authorization at any time, if I revoke my authorization, all information about me already in the database will remain.
- ✓ This release is valid for one year from the date of my signature below.
- ✓ I understand I may withdraw my consent at any time.
- ✓ I understand that the United Ways of South Central Nebraska Response System, the Central Navigator, and its partners and community assistance organizations cannot condition decisions about my treatment, payment, enrollment or eligibility for benefits or services on whether or not I sign this authorization. A copy of this authorization shall be as valid as the original.

Partner Agencies: A list of the partner agencies within the Nebraska Homeless Management Information System may be viewed prior to signing this form.

- ✓ Auditors or funders who have legal rights to review the work of this agency, including the U.S. Department of Housing and Urban Development and Nebraska Department of Health and Human Services Homeless Assistance Program may see my complete file in HMIS if services received are funded by their Department/s.

Please initial one of the following levels of consent:

____ I give authorization to have Protected Personal and relevant Information for me and my dependents entered into the NMIS and shared between Partner Agencies.

OR

____ I do not consent to the inclusion of personal information in the NMIS about me and any dependents.

Participant Name

Participant/Client Signature

Date

Witness Name

Witness Position Title

Witness Signature

Date

| | |
|---|--|
| Information to be completed by the referral agency and/or Central Navigator | |
| Referral agency – please fill in the following before submitting this form to the Central Navigator: | |
| Referral Agency Name: | |
| Contact Phone Number: | |
| Referral Staff Member Name: | |
| Contact Email Address: | |