

Our program requires 12 months or more acute housing. Signing this form acknowledges your agreement of such terms.



The Oasis of Houston, Inc.

A 501(c)(3) Nonprofit Organization

INTAKE/ASSESSMENT FORM

(This form must be completed within 30 days of program entry)

IDENTIFYING INFORMATION

Date Information is Gathered: _____

1. Applicant Last Name: _____ First Name: _____ MI: _____

2. Address: _____

3. City: _____ State: _____ Zip: _____ **Zip of Last Address:** _____

4. Phone where applicant can be reached: (ex. xxx-xxx-xxxx) _____

5. Social Security Number: _____ 6. Date of Birth: _____ 6a. Place of Birth: _____
(ex. NNN-NN-NNNN) (mm/dd/yyyy)

7. Gender: ___ a. Male ___ b. Female ___ c. Transgender

8. Race:
___ a. White ___ b. Black/African American ___ c. Asian
___ d. Multi-Racial (Please specify) _____

9. Ethnicity: ___ a. Hispanic or Latino ___ b. Non Hispanic or Non-Latino

10. What is applicant's primary language? _____ Secondary language, if applicable? _____

11. Relationship Status: ___ a. Single ___ b. Married ___ c. Widowed/Widower
___ d. Married & Separated ___ e. Divorced ___ f. Significant Other
___ g. Domestic Partner ___ h. Other (Specify) _____

12. Are there any identified, past or current, domestic violence issues? ___ Yes ___ No ___ Currently

a. Please describe, with dates of incidents. _____

13. Is applicant a Veteran, (anyone who has been on active military duty) ___ Yes ___ No

FAMILY

14. Enter family members that may live with the applicant (If applicable, complete attached Children's Education Form)

Name (Not Applicant)	Relationship to Applicant	Social Security Number	Gender	Date of Birth

a. Identify any service needs of applicants immediate family members: _____

b. Identify any family members who have been supportive: _____

c. Identify any family members who have not been supportive: _____

15. Enter family members that do not live with the applicant :

Family Providers Only

If the parent/guardian of children, identify the number of children and dates of birth of children living in the home. For Children age 6 or older, name of school attending, any after-school or activities the children are attending. For children age 0-5, identify participation in Head Start/Early Head Start, or school readiness, program, Birth to Three day dare. For school aged children, information about school attendance/absenteeism.

Name (Not Applicant)	Relationship to Applicant	Social Security Number	Gender	Date of Birth

15a. Child Welfare Involvement: For Parents of minor children, including non-custodial parents, history of child welfare involvement, including current case status: _____

15b. Identify the ability of the parent(s)/guardian(s) to meet the needs and ensure the safety of minor children. Identify parenting strengths and areas of support needed: _____

SUPPORTIVE HOUSING REFERRAL

16. Date of Referral _____ 17. Referring Person's Name: _____

18. Referring Person's Agency & Telephone Number: _____

19. Application Date: _____

HOUSING HISTORY

As part of questions 20 & 21, the attached Homelessness Verification Form needs to be completed.

20. Is this person at risk of homelessness? ____ Yes ____ No

a. Please describe circumstances: _____

21. Length of homelessness this episode:

- | | |
|---|---|
| ____ a. Not homeless at present | ____ e. At least 1 year but less than 2 years |
| ____ b. Less than one month | ____ f. Two years but less than three |
| ____ c. At least 1 month but less than 6 months | ____ g. Three years or more |
| ____ d. At least 6 months but less than 1 year | |

22. Number of episodes in past five years: _____

23. Approximate number in lifetime: _____

24. Within the last four (4) years, how many nights, months, or years, if any, have you spent in a shelter (s)? _____

a. Could you provide the names and dates of your shelter stay?: _____

25. Where have you slept for the last thirty (30) days? Check all that apply.

Check all that apply.

a. Non-housing (Street, park, car)	
b. Emergency Shelter, please name.	
c. Transitional Housing	
d. Psychiatric Facility	
e. Substance Abuse Treatment Facility	
f. Hospital	
g. Prison/Jail	
h. Domestic Violence Shelter	
i. Living with friends/family	
j. Rental Housing	
k. Own apartment or house	
l. Motel/hotel	
m. Foster Care	
n. Other (specify): _____	

26. Is applicant receiving a housing subsidy? Yes No

a. What type of housing subsidy is the applicant receiving? _____

27. Does/did applicant pay own rent? Yes No

28. Does/did applicant pay for own utilities? Yes No

29. Has applicant ever been evicted? Yes No

30. Reason for leaving last housing situation.

- a. Eviction due to unpaid rent
- b. Eviction for reason other than unpaid rent
- c. Conflict with friends or family
- d. Overcrowding
- e. Domestic violence
- f. Incarceration
- g. Hospitalization, including long term treatment
- h. Housing condemned
- i. Fire
- j. Other, please explain _____

31. Please list housing history for last five (5) years including: Location, approximate dates, lease holder or relationship to primary tenant, reason(s) for leaving. _____

31a. Please identify any contributing factors to housing instability: _____

PERSONAL HEALTH INFORMATION

As part of questions 32 & 33, the attached Disability Verification Form needs to be completed.

32. Does applicant have a disability of a long duration? Yes No Don't Know Refused

33. Is applicant currently or have they ever been diagnosed with any of the following?

- a. Mental illness..... Yes No Currently
- b. Alcohol abuse..... Yes No Currently
- c. Drug abuse..... Yes No Currently
- d. HIV/AIDS and related diseases..... Yes No Currently
- e. Developmental disability..... Yes No Currently
- f. Physical disability..... Yes No Currently

34. Does applicant have a history of any psychiatric conditions? Yes No

Check all that apply.

	Currently Experiences:	History of:
Homicidal ideas/attempts		
Assaultive behavior		
Delusions		
Severe depression		
Severe thought disorder		
Cognitive impairment		
Suicidal ideas		
Suicidal attempts		
Hallucinations		
Arson/fire setting		
Victim of Sexual abuse/assault		
Victim of Trauma		
Other (specify)		

a. If applicable, please list hospitalizations for these conditions.

35. Does applicant receive psychiatric care? Yes No

a. If yes, please list name, address and phone number of all psychiatric care providers.

36. Does applicant have a history of any substance abuse disorders? Yes No

a. If yes, please list drug(s) of choice, frequency of use, approximate date of last use.

37. Does applicant have any current or past history of substance abuse treatment? ____ Yes ____ No

a. If yes, please list name, address and phone number of all substance abuse providers.

38. Is applicant involved in any 12-step or other self help recovery programs? ____ Yes ____ No

a. If yes, which program(s)? _____

39. If applicant is substance free, for how long has s/he been substance free? _____

40. If applicant is currently using substances, is s/he interested in substance abuse treatment? ____ Yes ____ No

a. If no, what type of treatment is applicant interested in? _____

41. Does applicant have a history of any medical conditions? ____ Yes ____ No

a. If yes, please list conditions. If applicable, please list hospitalizations for these medical conditions.

41a. Date of last physical; OB/GYN, and dental appointments for all household members as appropriate: _____

42. Is applicant allergic to any medications? ____ Yes ____ No

a. If yes, please list medication allergies.

42A. PLEASE LIST CURRENT MEDICATIONS THE TENANT IS ON: _____

43. Where does applicant receive medical care? Please list name, address and phone number of all health care providers.

SOCIALIZATION

44. Describe applicant's participation in faith/spiritual activities, if any?

45. Describe applicant participate in any social networks, or recreational activities? Please list the name(s) of the social/recreational network:

VOCATIONAL & EDUCATION HISTORY

46. Does applicant or anyone living with him/her have a source of income? Yes No

a. What is the source of income? _____

47. Does applicant or anyone living with him/her have any entitlements pending? Yes No

a. What entitlement(s) is/are pending? _____

Person Receiving Income	Other's Name	Source of Income	Date Applied	Amount Receiving
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	a. Social Security Income (SSI)	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	b. Social Security Disability Income (SSDI)	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	d. General Assistance (SAGA)	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	e. Temporary Aid to Needy Families (TANF)	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	f. Child Support	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	n. Alimony	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	g. Veteran Benefits	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	h. Employment Income	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	i. Unemployment	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	j. Medicare	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	k. Medicaid	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	l. Food Stamps	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	m. Other (please specify)	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	n. No financial resources	_____	\$ _____

48. Please list any outstanding debts, including type of debt and amount: _____

49. Please list any financial obligations including the amount (e.g. child support, alimony): _____

50. Is applicant currently employed, either part-time or full-time? Yes No

a. If yes, where is applicant employed? _____

b. If no, does applicant wish to be employed, either now or in the future? Yes No

b2. If yes, in what area of employment does applicant wish to work? _____

c. Describe applicant's work experience or history, if applicable.

51. Does applicant need training or vocational support to achieve employment in desired occupation? Yes No

52. Is applicant currently participating in vocational or employment training programs? Yes No

a. If yes, please identify the training program? _____

b. If no, does applicant wish to enroll in a vocational or employment training program? Yes No

52a. Is applicant currently enrolled in an educational program, either part-time or full-time? Yes No

a. If yes, where is the applicant enrolled? _____

b. If no, does the applicant wish to be enrolled, either now or in the future? Yes No

LEGAL INFORMATION/HISTORY

53. Does applicant have any current legal issues? Yes No

a. If yes, please list description of charges and any pending court dates.

b. Does applicant have legal representation? Yes No

b2. If yes, please list name and address and phone number of attorney or legal advocate.

54. Is applicant currently on probation? Yes No

55. Is applicant currently on parole? Yes No

a. If yes to either #54 or #55, please list name and contact information of probation/parole officers(s)

56. Does applicant have any prior arrests, convictions or incarceration? Yes No

a. If yes, please list.

57. Does applicant have a conservator? ____ Yes ____ No
- a. If yes, is he/she a conservator of person? ____ Yes ____ No,
- b. If yes, is he/she conservator of estate (money)? ____ Yes ____ No
- c. If yes, is he/she conservator of both person and state? ____ Yes ____ No
- d. If yes, enter name and address of conservator:
-
-

ADL's

58. Does the applicant have difficulty with any of the following areas of daily living? In addition, please list any strengths the tenant may have.

Check all that apply.

a. Paying rent/utilities	
b. Lease compliance	
c. Housekeeping	
d. Money management	
e. Driving/using public transportation	
f. Arranging apartment repairs	
g. Use of mental health services	
h. Use of health services	
i. Securing/Maintaining Benefits	
j. Meal preparation	
k. Shopping for food and other necessities	
l. Taking medication as prescribed or instructed	
m. Filling prescriptions	
n. Socialization	
o. Hygiene	
p. Other (specify): _____	

EMERGENCY CONTACT

59. Emergency Contact: _____ Telephone # _____

Address: _____

Date of Application for Housing: _____

Applicant: _____ Date _____

Signature

Case Manager: _____ Date _____

Signature

Case Management Supervisor: _____ Date _____

Signature