*MDT Referring Entity: _____

*Referral Date: ____/____/____

HDAP Intake

CONTRA COSTA COUNTY
EMPLOYMENT & HUMAN SERVICES

First Name _____ Middle _____ Last Name _____ *Suffix ____

*SSN: _____ *DOB: _____ Agency/Program: _____

Case Manager: _____ Case Manager Phone: _____

Case Manager Email: _____

*Relationship to Head of Household (HoH): Self / HoH's child / HoH's spouse or partner / HoH's other relation member / Other: non-relation

Background Information

Best Phone No.: _____ Email Address: _____

Sex on Birth Certificate: ❑ Female ❑ Male ❑ Decline to state

***Gender:**
❑ Man (Boy if child) ❑ Woman (Girl if child) ❑ Transgender ❑ Questioning ❑ Non-Binary ❑ Culturally Specific Identity (e.g., Two-Spirit) ❑ Different Identity: _____ ❑ Client doesn't know ❑ Client prefers not to answer

***Sexual orientation:** ☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Questioning/Unsure ☐ Other: _____ ☐ Client prefers not to answer

***What Race BEST describes you? (circle all that apply)**
❑ White
❑ Asian or Asian American
❑ Black, African-American, or African
❑ American Indian/Alaskan Native/Indigenous
❑ Native Hawaiian or Pacific Islander
❑ Middle Eastern or North African
❑ Hispanic/Latina/e/o
❑ Client Doesn't Know
❑ Client prefers not to answer
❑ Additional Race and Ethnicity Detail: _____

***Do you need translation assistance: Yes / No If yes, preferred language(s)?** _____

***Have you ever served in the US Military?** Yes / No

If yes, Branch of the Military? (Circle one)
❑ Army ❑ Navy ❑ Airforce ❑ Marines ❑ Coast Guard ❑ Space Force

Year entered military service: _____ **Year separated from military service:** _____

Era (check all that apply):
❑ World War II ❑ Korean War ❑ Vietnam War ❑ Persian Gulf War ❑ Afghanistan ❑ Iraq Freedom ❑ Iraq Dawn ❑ Other Peace-keeping Operations

Discharge Status:
❑ Honorable ❑ General under honorable conditions ❑ Other than honorable (OTH) ❑ Bad Conduct ❑ Dishonorable ❑ Uncharacterized/Other ❑ Client doesn't know ❑ Client prefers not to answer

***Present Living Situation (circle one):**
❑ Emergency shelter, including hotel or motel paid for with emergency shelter voucher
❑ Place not meant for habitation including non-housing service site
❑ Other:_____

If place not meant for habitation, specify below:
❑ Street/sidewalk ❑ Vehicle ❑ Park ❑ Abandoned building ❑ Bus/train station ❑ Under a bridge /overpass ❑ Outdoor encampment/ woods

***Length of present living situation (circle one):**
❑ One night or less
❑ Two nights to six nights
❑ One week or more, but less than one month
❑ One month or more, but less than 90 days
❑ 90 Days or more, but less than one year
❑ One year or longer
❑ Client doesn't Know
❑ Client prefers not to answer

***If less than 30 days, where were you living before?** (See choices under Present Living Situation)_____

***Approximate date CURRENT episode of homelessness started (breaks of less than 7 days are acceptable)** ___ / ____ / _____

***Number of times you have been homeless on the streets/shelter in the PAST THREE YEARS including today:** _____

***Total Number of Months Homeless in the PAST THREE YEARS** [Note: Any single day or part of a month spent homeless should be counted as 1 month. Short breaks are acceptable]: _____ **months**

***City where you lost stable housing** _____ ***City Slept In Last Night:** _____

Is this your first time experiencing homelessness (being without housing)? Yes / No

Total length of time client has been homeless or without housing in lifetime _____ Years and _____Months

Housing Status at Program Entry
❑ Category 1 – Homeless (i.e. streets, shelter, transitional housing)
❑ Category 2 – At imminent risk of losing housing (within 14 days)
❑ Category 3 – Homeless only under other federal statutes
❑ Category 4 – Fleeing domestic violence
❑ At risk of homelessness
❑ Stably Housed

Cause of homelessness? (check all that apply)
❑ Divorce/Separation
❑ Loss of job
❑ Parole
❑ Substance abuse
❑ Physical health
❑ Domestic violence
❑ Low income /Underemployment
❑ Ran away
❑ Thrown out
❑ Eviction
❑ Mental health
❑ Rent increase
❑ Other:_____

What brought you to this city? (check one)

- ❑ I grew up here
- ❑ Family/friends live here
- ❑ This city is all I know
- ❑ Just passing through
- ❑ My services are here (i.e., doctor, MH, PO Box, Foodbank, church)
- ❑ Just released from local detention facility
- ❑ Just released from local hospital ER
- ❑ Just released from Psych Emergency
- ❑ Other: _____

Were you released as a result of AB109? Yes / No *__Domestic Violence Survivor?__ Yes / No

Are you currently on probation? Yes / No **If Yes, when last occurred?** _____

Are you currently on Parole? Yes / No **Are you currently fleeing?** Yes / No

Employed? ☐ Yes If Yes, what type? ☐ Full Time ☐ Part Time ☐ Seasonal (including Day Labor)
☐ No If No, why not? ☐ Looking for work ☐ Unable to work ☐ Not Looking for Work

Have you ever willingly performed or been threatened, coerced, or manipulated to perform a sexual act in exchange for money/goods? Yes / No

Have you ever been threatened, coerced, or manipulated to work without pay? Yes / No

Monthly Income

Income from Any Source? ☐ Yes ☐No If yes, write the monthly amounts below

Earned Income	$	SSDI	$	TANF	$
Unemployment Insurance	$	SSI	$	GA	$
Workers Compensation	$	Retirement Income from Social Security	$	Alimony Spousal Support	$
Private Disability Insurance	$	VA Non-Service Connected Disability	$	Child Support	$
VA Service-Connected Disability	$	Pension or Retirement from a Former Job	$	Other (Specify):	$

Non Cash Benefits

Receiving Non Cash Benefits? ☐ Yes ☐ No If yes, check all that apply

☐SNAP Supplemental Nutrition Assistance Program (Food Stamps) ☐TANF Childcare Services ☐Other TANF- Funded Services

☐WIC Special Supplemental Nutrition Program for Women, Infants, & Children ☐TANF Transportation Services ☐Other (Specify): _____

Health Insurance

Covered by Health Insurance? ☐ Yes ☐ No If yes, check all that apply

☐Medicaid ☐Veteran's Health Administration (VHA) ☐Private Pay Health Insurance ☐Other Health Insurance

☐Medicare ☐Employer-Provided Health Insurance ☐State Health Insurance for Specify Other: _____

☐State Children's Health Insurance Program ☐COBRA ☐Indian Health Services

*Disabilities: Please circle Yes or No for EACH of the following

Physical	Yes / No	**Long Term?:** Yes / No	**Mental health disorder**	Yes / No	**Long Term?:** Yes / No
Developmental	Yes / No	**Impairs Independence?** Yes / No	**Alcohol use disorder**	Yes / No	**Long Term?:** Yes / No
Chronic health condition	Yes / No	**Long Term?:** Yes / No	**Drug use disorder**	Yes / No	**Long Term?:** Yes / No
HIV/AIDS	Yes / No	**Impairs Independence?** Yes / No	**Both Alcohol and Drug use**	Yes / No	**Long Term?:** Yes / No

Note: Chronic health condition – a diagnosed condition that is more than three months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples include but are not limited to: heart disease, severe asthma, diabetes, arthritis-related conditions, adult onset cognitive impairments (including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive related conditions), severe headache/migraine, cancer, chronic bronchitis, liver condition, stroke, or emphysema.

***Do you have a Disabling Condition?** **(Do you have a condition of expected long duration that substantially limits your ability to work and maintain housing?)**

❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer

Approval Date: **Denial Date:**

Contact

Time of Contact: ___:_____

***Location of Contact:**

- ❑ Not staying on streets,ES,EH
- ❑ Staying on the streets ,ES,EH
- ❑ Worker unable to determine

***City of Contact:** _____

Encampment/Location:

Services Provided (Referral/Placement/Coordination)

Indicate which shelter, facility, center

- ❑ **Shelter:** _____ R / P
- ❑ **AOD Treatment :** _____ R / P
- ❑ **Hospital:** _____ R / C
- ❑ **Outpatient Medical :** _____ R / C
- ❑ **MH Clinic:** _____ R / C
- ❑ **CARE Center :** _____ R / C
- ❑ **Benefits worker – Specify benefits** _____ R / C
- ❑ **HCH Mobile Clinic:** _____ R / C
- ❑ **Warming Center**: ___ _____ R / P

- ❑ Warming Center (East)
- ❑ Warming Center (West)
- ❑ Sobering Center
- ❑ DMV
- ❑ Medication Pick-Up
- ❑ VASH/SSVF/VA Benefit Referral
- ❑ Bus/BART Ticket(#):_____
- ❑ Animal Services
- ❑ Emergency Supplies

Emergency Contact Person _____ **Phone No.** _____