

Client Intake Form

AGENCY NAME: _____ **PROJECT NAME:** _____ **TYPE OF PROGRAM:** _____
 (check one)
ADDRESS: _____ **Out-of-School**
 Participant Last Name First Name MI Number Direction Street Name Apt. No. ☐ PI
☐ CHA
TELEPHONE NUMBER: () _____ **Chicago, IL 606** **Homeless Youth**

ETHNICITY: (check one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		GENDER: (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	AGE: _____	BIRTHDATE: _____
RACE: (check one) <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other Multi racial		CURRENT GRADE (if in school) or HIGHEST LEVEL OF EDUCATION COMPLETED: _____ SCHOOL: _____ DISABLED: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify _____ Community Area: _____ Ward: _____		

HEAD OF HOUSEHOLD INFORMATION

FAMILY TYPE: (check one) <input type="checkbox"/> Single Parent/Female <input type="checkbox"/> Single Parent/Male <input type="checkbox"/> Two-parent household <input type="checkbox"/> Independent Youth <input type="checkbox"/> Relative <input type="checkbox"/> Guardian	HOUSING STATUS: (check one) <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Homeless/Shelter <input type="checkbox"/> In Temporary Housing	FOOD STAMPS: (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No FREE/REDUCED LUNCH: (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No HEALTH INSURANCE: (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No	INCOME SOURCE (check all that apply) <input type="checkbox"/> Employment <input type="checkbox"/> Pension <input type="checkbox"/> TANF <input type="checkbox"/> Earnfare <input type="checkbox"/> Social Security <input type="checkbox"/> Unemployment Insurance <input type="checkbox"/> Other (Including SSDI, Child Support and VA Benefits) <input type="checkbox"/> SSI
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SOURCE OF REFERRAL (Location that sent you) _____ **CHA Client ID#:** _____

Signature of Applicant (Date) _____

Intake Worker's Signature (Date) _____

PARENT OR GUARDIAN'S STATEMENT: I certify that the above information is accurate and I give my permission for the above named to participate in this program.

Signature* of Parent or Guardian

Date

*Required for all participants 17 years of age or younger Please refer to Income table to