



INTAKE FORM

What type of assistance are you in need of?

Today's date _____ Birth Name _____

Preferred name: _____ Pronouns: _____

Date of Birth: ___/___/___

Race: White Black Asian American Indian Other: _____

Country of Origin _____

Gender M F O

Social Security # _____ - _____ - _____ Tel.# () _____ Cell Phone #: _____

Address: _____ Email Address _____

How long at this address? _____ Landlord Name: _____

Landlord Address: _____ Landlord Phone # _____

Your previous address (Include City/State/Zip) _____

Primary Source of Heat t

Reason(s) for moving to Norwich: (please circle all that apply) Casino Job Housing
 Family Completed Substance Abuse Treatment Other: _____

How long have you lived in Norwich? _____

Do you live in subsidized housing? yes _____ no _____ Do You Have Renters Insurance? Yes _____ no _____

Have you received an eviction notice? yes _____ no _____ When? _____

Have you received a utility shut-off notice? _____

x
 Are you working with the Dept. of Children & Families in any way? yes _____ no _____

Why are you in need of assistance?

Divorced, Separated, Widowed _____ Loss of Employment _____ Prison Release _____

Discharge from treatment _____ Need medical coverage _____ Other _____

How were you referred to this training program/agency? _____

~Please list ALL members of your household, including non-related roommates~

6 kids _____ DOB _____ Relationship _____

DOB _____ Relationship _____

DOB _____ Relationship _____

Name _____ Age _____ DOB ___ / ___ / ___ Relationship _____

Name _____ Age _____ DOB ___ / ___ / ___ Relationship _____

Marital Status: Single Married Divorced Widowed Seperated Civil Union

Do you have a child who is a high school junior or senior? _____ Yes _____ No

MEDICAL HISTORY

Do you or anyone in your family have a serious medical condition? yes ___ no ___

If yes, please explain: _____

What are your primary medical concerns/issues? _____

Have you been hospitalized in the last year? _____ If so, where? _____

Reason _____

Current medications _____

Do you have: Drug/alcohol problem ___ Gambling problem ___ Mental Health Concerns ___

Have you been in a drug/alcohol rehabilitation program? ___ If yes, where? _____

Have you received mental health services? ___ If yes, where? _____

Are you still in treatment? Yes ___ no ___ Length: ___ Interested? ___

Do you have Medical Insurance? ___ Name _____ ID # _____

Education/Employment History

What is your level of education? High School/incomplete High School/GED College

Trade/Vocational Graduate School or higher

Employed: Full Time Part Time Seasonal Retired

Unemployed: Disabled Temp

If unemployed, have you filed for unemployment compensation? yes ___ no ___

What is your expected weekly benefits? _____

Arrest History

Date: _____ Charge: _____

Date: _____ Charge: _____

Date: _____ Charge: _____

Date: _____ Charge: _____

Do you have any charges pending? (if yes, please explain) _____

Are you on the Sex Offender Registry? Yes No

Emergency Contact Information

Name _____

Phone Number _____

Address _____

City _____ State _____ Zip Code _____

Financial Information

Please include monthly income for ALL MEMBERS OF HOUSEHOLD

HOUSEHOLD MONTHLY INCOME		HOUSEHOLD MONTHLY BILLS / EXPENSES		Amount Behind
Employment:		Rent/Mortgage:		
UCOMP:		Utilities/Fuel		\$
Social Security:		Food:		\$
State Supplement:	\$	Telephone:		\$
Child Support:		Cable:		\$
SAGA Cash:	\$	Auto Payment:		\$
Pension:	\$	Auto Insurance:		\$
VA Benefits:	\$	Credit Card(s):		\$
TFA/TANF:		Childcare:		\$
Food Stamps:		Rent-A-Center:		\$
Others:		Cigarette/Tabacco:	\$	\$
	\$	Other:	\$	\$
Medical Insurance:	state	Child support		\$
Free/Reduced Lunch:	Yes No	Child care		\$
Medicare Savings:	Yes No		\$	\$
Energy Assistance:	Yes No		\$	\$
TOTAL:	\$	TOTAL:	\$	\$

In the last 24 months, have you received ANY lump sums of money, such as a lawsuit settlement, Income Tax return, or Worker's Compensation claim settlement? **Y N**

Identification Numbers CI #, Medicare #, etc.
 Description _____ ID # _____
 Description _____ ID # _____
 Description _____ ID # _____

I, _____ (DOB _____, SSN _____ - _____ - _____), authorize
 Norwich Human Services to contact State DSS for purposes of clarification of benefits and/or advocacy
 on my behalf. This release will expire one year from date below.

 Signature

 Date: