

Family Resource Center Intake Form



Please fill out both sides of this form

Date:		Cell Phone: <input type="checkbox"/> ok to leave message	
Legal Last Name:		Home Phone: <input type="checkbox"/> ok to leave message	
Legal First Name:	MI:	E-Mail:	
Address:		Place of Birth:	
City:	Zip Code:	Date Came to the USA:	
Primary Language:		Emergency Contact Name:	
Other Language(s):		Relationship of Emergency Contact:	
Number of People Living in Home:		Emergency Phone: <input type="checkbox"/> ok to leave message	
Relationship Status:	Family Type:	Housing Status:	Military History:
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Separated	<input type="checkbox"/> Single Parent <input type="checkbox"/> Two Parent Household <input type="checkbox"/> Single Person <input type="checkbox"/> Two Adults / No Children <input type="checkbox"/> Multi-Family Household <input type="checkbox"/> Other: _____	<input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Homeless <input type="checkbox"/> Temporary <input type="checkbox"/> Roommate <input type="checkbox"/> Shelter: _____	<input type="checkbox"/> Active <input type="checkbox"/> Active Duty <input type="checkbox"/> Veteran <input type="checkbox"/> Dependent <input type="checkbox"/> Branch: _____ <input type="checkbox"/> None
Total household GROSS INCOME per month for ALL PEOPLE living in the home (including roommates and non-family members)		Total household EXPENSES per month for ALL PEOPLE living in the home (including roommates and non-family members)	
<input type="checkbox"/> TANF / Calworks: \$ _____ <input type="checkbox"/> Other Public Source: \$ _____ <input type="checkbox"/> SSI / SSA: \$ _____ <input type="checkbox"/> SSDI / SSD: \$ _____ <input type="checkbox"/> Unemployment: \$ _____ <input type="checkbox"/> Employment: \$ _____ Type of Work: _____ <input type="checkbox"/> Child Support / Alimony: \$ _____ Court Ordered or Voluntary?: _____ <input type="checkbox"/> Food Stamps (CalFresh / SNAP): \$ _____ <input type="checkbox"/> Financial Aid: \$ _____ School: _____ <input type="checkbox"/> Other (Please Specify): \$ _____ TOTAL MONTHLY INCOME: \$ _____		<input type="checkbox"/> Rent / Mortgage: \$ _____ <input type="checkbox"/> Car Payment: \$ _____ <input type="checkbox"/> Insurance: \$ _____ <input type="checkbox"/> Utilities (Water / SDGE): \$ _____ <input type="checkbox"/> Groceries: \$ _____ <input type="checkbox"/> Telephone: \$ _____ <input type="checkbox"/> Childcare: \$ _____ <input type="checkbox"/> Student Loan: \$ _____ <input type="checkbox"/> Credit Card: \$ _____ <input type="checkbox"/> Other: \$ _____ Please Specify: _____ TOTAL MONTHLY EXPENSES: \$ _____	

I acknowledge receipt of the Notice of Privacy Rights, which I have reviewed and give my permission to The Salvation Army Ray and Joan Kroc Corps Community Center Family Resource Center to use and disclose my health information in accordance with it.

CLIENT SIGNATURE: _____

DATE: _____

Please complete for ALL persons living in the household (including roommates, landlords, and/or non-family members)

Name:	Relationship to you:	Sex:	Date of Birth:	Health Insurance:	Education Level:	Ethnicity:	Disability:
Last: First: MI:	Self	<input type="checkbox"/> Male <input type="checkbox"/> Female	Month: Day: Year:	<input type="checkbox"/> Medi-Cal <input type="checkbox"/> Healthy Families <input type="checkbox"/> Private <input type="checkbox"/> Other	<input type="checkbox"/> High School <input type="checkbox"/> G.E.D. <input type="checkbox"/> Associate Degree <input type="checkbox"/> Some College <input type="checkbox"/> College Graduate <input type="checkbox"/> Trade/Technical <input type="checkbox"/> Post Graduate <input type="checkbox"/> Not Applicable	<input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> African American/Black <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Native American <input type="checkbox"/> White (Non-Hispanic) <input type="checkbox"/> Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Describe:
Last: First: MI:		<input type="checkbox"/> Male <input type="checkbox"/> Female	Month: Day: Year:	<input type="checkbox"/> Medi-Cal <input type="checkbox"/> Healthy Families <input type="checkbox"/> Private <input type="checkbox"/> Other	<input type="checkbox"/> High School <input type="checkbox"/> G.E.D. <input type="checkbox"/> Associate Degree <input type="checkbox"/> Some College <input type="checkbox"/> College Graduate <input type="checkbox"/> Trade/Technical <input type="checkbox"/> Post Graduate <input type="checkbox"/> Not Applicable	<input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> African American/Black <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Native American <input type="checkbox"/> White (Non-Hispanic) <input type="checkbox"/> Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Describe:
Last: First: MI:		<input type="checkbox"/> Male <input type="checkbox"/> Female	Month: Day: Year:	<input type="checkbox"/> Medi-Cal <input type="checkbox"/> Healthy Families <input type="checkbox"/> Private <input type="checkbox"/> Other	<input type="checkbox"/> High School <input type="checkbox"/> G.E.D. <input type="checkbox"/> Associate Degree <input type="checkbox"/> Some College <input type="checkbox"/> College Graduate <input type="checkbox"/> Trade/Technical <input type="checkbox"/> Post Graduate <input type="checkbox"/> Not Applicable	<input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> African American/Black <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Native American <input type="checkbox"/> White (Non-Hispanic) <input type="checkbox"/> Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Describe:
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