## COVER and SIGNATURE PAGE

**Intake Date:** ______________

**Eligibility Criteria** (all criteria must be met for CARES eligibility)

- ☐ Resident of Multnomah County
- ☐ Negatively impacted by COVID-19 (See "COVID-19 Impact" items below)*
- ☐ 80% or below area median income

| 80% Area Median Income Guidelines | | | |
|---|---|---|---|
| Family Size | **80% Median** | Family Size | **80% Median** |
| 1 | **$51,600** | 5 | **$79,600** |
| 2 | **$58,960** | 6 | **$85,520** |
| 3 | **$66,320** | 7 | **$91,440** |
| 4 | **$73,680** | 8 | **$97,280** |

***Covid-19 Impact** (select all that apply)

- ☐ A loss of income due to COVID-19 related factors
- ☐ Compromised health status or elevated risk of infection or vulnerability to COVID-19
- ☐ Diagnosed or exposed to COVID-19
- ☐ Other (please indicate):
- ☐ Declined to Respond

**Head of Household Information**

| **Name** (First and Last) | | **Phone Number** |
|---|---|---|
| **Street Address** | | **City** |
| **State** | **ZIP** | **Email** |

**Landlord Information** (to send payment)

| **Name** | | **Phone Number** |
|---|---|---|
| **Street Address** | | **City** |
| **State** | **ZIP** | **Email** |

**Household Income**

| **Monthly Income** (in the last 30 days) | **Annual Income** |
|---|---|

**Assistance Received**

| **Rent Payment Type** | **Month(s)** | **Amount** | **Fund Source (admin only)** | | |
|---|---|---|---|---|---|
| | | | City CARES | County CARES | County Non-CARES |
| | | | | | |
| | | | | | |
| | | | | | |
| **Utility Company** | **Month(s)** | **Amount** | **Fund Source (admin only)** | | |
| | | | | | |
| | | | | | |
| | | | | | |
| **Security Deposit Payment** | **Date Paid** | **Amount** | **Fund Source (admin only)** | | |
| | | | | | |

*"I certify that the information on this intake form is true and accurate to the best of my knowledge. I also certify that I have not received rental assistance due to COVID-19 for the same month(s) from a different organization or program."*

Client Signature ______________________________ Date ______________

Case Worker/Agency Staff Signature ______________________________ Date ______________

## HEAD OF HOUSEHOLD (HoH) Data (1 of 2)

**ServicePoint Client ID for HoH:** ___________

| | |
|---|---|
| **First Name** | **Last Name** |
| **Date of Birth** (MM/DD/YYYY): | **Housing Move-in Date:** (must be on or after intake date) |

**Social Security Number (SSN)** (Please indicate how much of your SSN you are willing to share)
☐ Full ☐ Last 4 digits ☐ Declined to Respond SSN: __ __ __ - __ __- __ __ __ __

**Primary Language:**

**US Military Veteran?** ☐ Yes ☐ No ☐ Declined to Respond

**Gender** ☐ Female ☐ Male ☐ Trans Female (Male to Female) ☐ Trans Male (Female to Male) ☐ Gender Non-Conforming (not exclusively male or female) ☐ Declined to Respond

**Race** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Declined to Respond

**Additional Race** (Select all that apply) ☐ African ☐ Middle Eastern ☐ Slavic

**Ethnicity** ☐ Non-Hispanic/Non-Latino ☐ Hispanic/Latino ☐ Declined to Respond

**Disability Type** (Select all that apply) ☐ None ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol and Drug Abuse ☐ Chronic Health Condition ☐ Developmental ☐ HIV/AIDS ☐ Hearing Impaired ☐ Mental Health ☐ Physical ☐ Vision Impaired ☐ Declined to Respond ☐ Other:

**Health Insurance** (Select all that apply) ☐ None ☐ COBRA ☐ Employer Provided ☐ Medicaid ☐ Medicare ☐ Indian Health Services Program ☐ Private Pay ☐ SCHIP ☐ VA Medical Services ☐ Declined to Respond ☐ Other:

**Non-Cash Benefits** (Select all that apply) ☐ None ☐ SNAP ☐ WIC ☐ TANF Child Care Services ☐ TANF Transportation Services ☐ Other TANF-Funded Services ☐ Declined to Respond ☐ Other (Describe):

**Income** (Fill in all that apply according to funding eligibility requirements)

| Monthly Amount | | Monthly Amount | |
|---|---|---|---|
| $____________ | Alimony or Other Spousal Support | $____________ | Supplemental Security Income (SSI) |
| $____________ | Child Support | $____________ | Social Security Disability Insurance (SSDI) |
| $____________ | Earned Income (wages, salary, etc.) | $____________ | TANF |
| $____________ | General Assistance | $____________ | Unemployment Insurance |
| $____________ | Pension or retirement income | $____________ | VA Non-Service Connected Disability Pension |
| $____________ | Private Disability Insurance | $____________ | VA Service Connected Disability Compensation |
| $____________ | Retirement Income from Social Security | $____________ | Worker's Compensation |
| $____________ | Self Employment Wages | $____________ | Other: |

☐ None ☐ Declined to Respond

**Percent of Median Family Income** (Select one option) ☐ 0-30% MFI ☐ 30-50% MFI ☐ 50-80% MFI ☐ Over 80% MFI ☐ Declined to Respond

## HEAD OF HOUSEHOLD (HoH) Data (2 of 2)

**Residence Prior to Project Entry**

Select only ONE option from "homeless", "institutional" OR "transitional and permanent housing" situation.

HOMELESS SITUATION

- ☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
- ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter
- ☐ Safe Haven

INSTITUTIONAL SITUATION

- ☐ Foster care home or foster care group home
- ☐ Hospital or other residential non-psychiatric medical facility
- ☐ Jail, prison or juvenile detention facility
- ☐ Long-term care facility or nursing home
- ☐ Psychiatric hospital or other psychiatric facility
- ☐ Substance abuse treatment facility or detox center

TRANSITIONAL AND PERMANENT HOUSING SITUATION

- ☐ Residential project or halfway house with no homeless criteria
- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Transitional housing for homeless persons (including homeless youth)
- ☐ Host Home (non-crisis)
- ☐ Staying or living in a friend's room, apartment or house
- ☐ Staying or living in a family member's room, apartment or house
- ☐ Rental by client, with GPD TIP subsidy
- ☐ Rental by client, with VASH subsidy
- ☐ Permanent housing (other than RRH) for formerly homeless persons
- ☐ Rental by client, with RRH or equivalent subsidy
- ☐ Rental by client, with HCV voucher (tenant or project based)
- ☐ Rental by client in a public housing unit
- ☐ Rental by client, no ongoing housing subsidy
- ☐ Rental by client, with other ongoing subsidy
- ☐ Owned by client, with ongoing housing subsidy
- ☐ Owned by client, no ongoing housing subsidy

- ☐ Declined to Respond

**Length of Stay in Previous Residence** (Select one option. "Previous Residence" is the location marked as "Residence Prior…" above):

- ☐ One night or less
- ☐ Two 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
- ☐ Declined to Respond

Answer this question if residence prior to program entry is:

- a homeless situation OR
- an institutional situation for less than 90 days OR
- a permanent or transitional situation for less than seven days.

Otherwise, skip to next page.

**Did you stay on the streets or in shelter the night before?** (Select one option)

- ☐ Yes
- ☐ No
- ☐ Declined to Respond

Only complete the remaining questions on this page if you answered "Yes" to "Did you stay on the streets on in shelter the night before?" above. If you answered "No" or "Declined to Respond", skip to the next page.

**Number of times homeless in the last three years** (Select one option)

- ☐ One time
- ☐ Two times
- ☐ Three times
- ☐ Four or more times
- ☐ Declined to Respond

**Approximate date current period of homelessness started** (MM/DD/YYYY) ______________________

**Total number of months homeless in the last three years** (Select one option)

- ☐ Less than 12 months
  Number of months: __________
- ☐ 12 or more months

## OTHER ADULT (18+ years of age) Data (1 of 2)

**First Name** | **Last Name**

**Date of Birth** (MM/DD/YYYY):

**Relationship to Head of Household** ☐ Child ☐ Spouse or Partner ☐ Other relation member ☐ Non-relation member

**Social Security Number (SSN)** (Please indicate how much of your SSN you are willing to share)
☐ Full ☐ Last 4 digits ☐ Declined to Respond SSN: __ __ __ - __ __- __ __ __ __

**Primary Language:**

**US Military Veteran?** ☐ Yes ☐ No ☐ Declined to Respond

**Gender** ☐ Female ☐ Male ☐ Trans Female (Male to Female) ☐ Trans Male (Female to Male) ☐ Gender Non-Conforming (not exclusively male or female) ☐ Declined to Respond

**Race** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Declined to Respond

**Additional Race** (Select all that apply) ☐ African ☐ Middle Eastern ☐ Slavic

**Ethnicity** ☐ Non-Hispanic/Non-Latino ☐ Hispanic/Latino ☐ Declined to Respond

**Disability Type** (Select all that apply) ☐ None ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol and Drug Abuse ☐ Chronic Health Condition ☐ Developmental ☐ HIV/AIDS ☐ Hearing Impaired ☐ Mental Health ☐ Physical ☐ Vision Impaired ☐ Declined to Respond ☐ Other:

**Health Insurance** (Select all that apply) ☐ None ☐ COBRA ☐ Employer Provided ☐ Medicaid ☐ Medicare ☐ Indian Health Services Program ☐ Private Pay ☐ SCHIP ☐ VA Medical Services ☐ Declined to Respond ☐Other:

**Non-Cash Benefits** (Select all that apply) ☐ None ☐ SNAP ☐ WIC ☐ TANF Child Care Services ☐ TANF Transportation Services ☐ Other TANF-Funded Services ☐ Declined to Respond ☐ Other (Describe):

**Income** (Fill in all that apply according to funding eligibility requirements)

| Monthly Amount | | Monthly Amount | |
|---|---|---|---|
| $______________ | Alimony or Other Spousal Support | $______________ | Supplemental Security Income (SSI) |
| $______________ | Child Support | $______________ | Social Security Disability Insurance (SSDI) |
| $______________ | Earned Income (wages, salary, etc.) | $______________ | TANF |
| $______________ | General Assistance | $______________ | Unemployment Insurance |
| $______________ | Pension or retirement income | $______________ | VA Non-Service Connected Disability Pension |
| $______________ | Private Disability Insurance | $______________ | VA Service Connected Disability Compensation |
| $______________ | Retirement Income from Social Security | $______________ | Worker's Compensation |
| $______________ | Self Employment Wages | $______________ | Other: |

☐ None ☐ Declined to Respond

**Percent of Median Family Income** (Select one option) ☐ 0-30% MFI ☐ 30-50% MFI ☐ 50-80% MFI ☐ Over 80% MFI ☐ Declined to Respond

## OTHER ADULT (18+ years of age) Data (2 of 2)

**Residence Prior to Project Entry**
Select only ONE option from "homeless", "institutional" OR "transitional and permanent housing" situation.

| HOMELESS SITUATION | INSTITUTIONAL SITUATION | TRANSITIONAL AND PERMANENT HOUSING SITUATION |
|---|---|---|
| ☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)<br>☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter<br>☐ Safe Haven | ☐ Foster care home or foster care group home<br>☐ Hospital or other residential non-psychiatric medical facility<br>☐ Jail, prison or juvenile detention facility<br>☐ Long-term care facility or nursing home<br>☐ Psychiatric hospital or other psychiatric facility<br>☐ Substance abuse treatment facility or detox center | ☐ Residential project or halfway house with no homeless criteria<br>☐ Hotel or motel paid for without emergency shelter voucher<br>☐ Transitional housing for homeless persons (including homeless youth)<br>☐ Host Home (non-crisis)<br>☐ Staying or living in a friend's room, apartment or house<br>☐ Staying or living in a family member's room, apartment or house<br>☐ Rental by client, with GPD TIP subsidy<br>☐ Rental by client, with VASH subsidy<br>☐ Permanent housing (other than RRH) for formerly homeless persons<br>☐ Rental by client, with RRH or equivalent subsidy<br>☐ Rental by client, with HCV voucher (tenant or project based)<br>☐ Rental by client in a public housing unit<br>☐ Rental by client, no ongoing housing subsidy<br>☐ Rental by client, with other ongoing subsidy<br>☐ Owned by client, with ongoing housing subsidy<br>☐ Owned by client, no ongoing housing subsidy<br><br>☐ Declined to Respond |

**Length of Stay in Previous Residence** (Select one option. "Previous Residence" is the location marked as "Residence Prior…" above):

- ☐ One night or less
- ☐ Two 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
- ☐ Declined to Respond

Answer this question if residence prior to program entry is:

- a homeless situation OR
- an institutional situation for less than 90 days OR
- a permanent or transitional situation for less than seven days.

Otherwise, skip to next page.

**Did you stay on the streets or in shelter the night before?** (Select one option)

- ☐ Yes
- ☐ No
- ☐ Declined to Respond

Only complete the remaining questions on this page if you answered "Yes" to "Did you stay on the streets on in shelter the night before?" above. If you answered "No" or "Declined to Respond", skip to the next page.

**Number of times homeless in the last three years** (Select one option)

- ☐ One time
- ☐ Two times
- ☐ Three times
- ☐ Four or more times
- ☐ Declined to Respond

**Approximate date current period of homelessness started** (MM/DD/YYYY) ____________________

**Total number of months homeless in the last three years** (Select one option)

- ☐ Less than 12 months
  Number of months: ________
- ☐ 12 or more months

## CHILD (under 18 years of age) Data (Page 1 of 1)

| **First Name** | **Last Name** |
|---|---|
| **Date of Birth** (MM/DD/YYYY): | **Relationship to Head of Household** ☐ Child ☐ Spouse or Partner ☐ Other relation member ☐ Non-relation member |

**Social Security Number (SSN)** (Please indicate how much of your SSN you are willing to share)
☐ Full ☐ Last 4 digits ☐ Declined to Respond SSN: __ __ __ - __ __- __ __ __ __

**Primary Language:**

**Gender** ☐ Female ☐ Male ☐ Trans Female (Male to Female) ☐ Trans Male (Female to Male) ☐ Gender Non-Conforming (not exclusively male or female) ☐ Declined to Respond

**Race** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Declined to Respond

| **Additional Race** (Select all that apply) | ☐ African<br>☐ Middle Eastern<br>☐ Slavic | **Ethnicity** | ☐ Non-Hispanic/Non-Latino<br>☐ Hispanic/Latino<br>☐ Declined to Respond |
|---|---|---|---|

| **Disability Type** (Select all that apply) | | | | |
|---|---|---|---|---|
| | ☐ None | ☐ Chronic Health Condition | ☐ Hearing Impaired | ☐ Declined to Respond |
| | ☐ Alcohol Abuse | ☐ Developmental | ☐ Mental Health | ☐ Other: |
| | ☐ Drug Abuse | ☐ HIV/AIDS | ☐ Physical | |
| | ☐ Both Alcohol and Drug Abuse | | ☐ Vision Impaired | |

| **Health Insurance** (Select all that apply) | | | | |
|---|---|---|---|---|
| | ☐ None | ☐ Medicaid | ☐ Private Pay | ☐ Declined to Respond |
| | ☐ COBRA | ☐ Medicare | ☐ SCHIP | ☐ Other: |
| | ☐ Employer Provided | ☐ Indian Health Services Program | ☐ VA Medical Services | |

## CHILD (under 18 years of age) Data (Page 1 of 1)

| **First Name** | **Last Name** |
|---|---|
| **Date of Birth** (MM/DD/YYYY): | **Relationship to Head of Household** ☐ Child ☐ Spouse or Partner ☐ Other relation member ☐ Non-relation member |

| | | | | |
|---|---|---|---|---|
| **Social Security Number (SSN)** (Please indicate how much of your SSN you are willing to share) | | | | |
| ☐ Full | ☐ Last 4 digits | ☐ Declined to Respond | SSN: __ __ __ - __ __- __ __ __ __ | |
| **Primary Language:** | | | | |
| **Gender** | ☐ Female<br>☐ Male | ☐ Trans Female (Male to Female)<br>☐ Trans Male (Female to Male) | ☐ Gender Non-Conforming (not exclusively male or female)<br>☐ Declined to Respond | |
| **Race** | ☐ American Indian/Alaska Native<br>☐ Asian | ☐ Black/African American<br>☐ Native Hawaiian/Pacific Islander | ☐ White<br>☐ Declined to Respond | |
| **Additional Race** (Select all that apply) | ☐ African<br>☐ Middle Eastern<br>☐ Slavic | **Ethnicity** | ☐ Non-Hispanic/Non-Latino<br>☐ Hispanic/Latino<br>☐ Declined to Respond | |
| **Disability Type** (Select all that apply) | ☐ None<br>☐ Alcohol Abuse<br>☐ Drug Abuse<br>☐ Both Alcohol and Drug Abuse | ☐ Chronic Health Condition<br>☐ Developmental<br>☐ HIV/AIDS | ☐ Hearing Impaired<br>☐ Mental Health<br>☐ Physical<br>☐ Vision Impaired | ☐ Declined to Respond<br>☐ Other: |
| **Health Insurance** (Select all that apply) | ☐ None<br>☐ COBRA<br>☐ Employer Provided | ☐ Medicaid<br>☐ Medicare<br>☐ Indian Health Services Program | ☐ Private Pay<br>☐ SCHIP<br>☐ VA Medical Services | ☐ Declined to Respond<br>☐ Other: |

## CHILD (under 18 years of age) Data (Page 1 of 1)

| **First Name** | **Last Name** |
|---|---|
| **Date of Birth** (MM/DD/YYYY): | **Relationship to Head of Household** ☐ Child ☐ Spouse or Partner ☐ Other relation member ☐ Non-relation member |
| **Social Security Number (SSN)** (Please indicate how much of your SSN you are willing to share)<br>☐ Full ☐ Last 4 digits ☐ Declined to Respond SSN: __ __ __ - __ __- __ __ __ __ | |
| **Primary Language:** | |
| **Gender** ☐ Female ☐ Male ☐ Trans Female (Male to Female) ☐ Trans Male (Female to Male) ☐ Gender Non-Conforming (not exclusively male or female) ☐ Declined to Respond | |
| **Race** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Declined to Respond | |
| **Additional Race** (Select all that apply) ☐ African ☐ Middle Eastern ☐ Slavic | **Ethnicity** ☐ Non-Hispanic/Non-Latino ☐ Hispanic/Latino ☐ Declined to Respond |
| **Disability Type** (Select all that apply) ☐ None ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol and Drug Abuse ☐ Chronic Health Condition ☐ Developmental ☐ HIV/AIDS ☐ Hearing Impaired ☐ Mental Health ☐ Physical ☐ Vision Impaired ☐ Declined to Respond ☐ Other: | |
| **Health Insurance** (Select all that apply) ☐ None ☐ COBRA ☐ Employer Provided ☐ Medicaid ☐ Medicare ☐ Indian Health Services Program ☐ Private Pay ☐ SCHIP ☐ VA Medical Services ☐ Declined to Respond ☐ Other: | |

## CHILD (under 18 years of age) Data (Page 1 of 1)

| | | | |
|---|---|---|---|
| **First Name** | | **Last Name** | |
| **Date of Birth** (MM/DD/YYYY): | **Relationship to Head of Household** | ☐ Child<br>☐ Spouse or Partner | ☐ Other relation member<br>☐ Non-relation member |
| **Social Security Number (SSN)** (Please indicate how much of your SSN you are willing to share)<br>☐ Full ☐ Last 4 digits ☐ Declined to Respond SSN: __ __ __ - __ __- __ __ __ __ | | | |
| **Primary Language:** | | | |
| **Gender** | ☐ Female<br>☐ Male | ☐ Trans Female (Male to Female)<br>☐ Trans Male (Female to Male) | ☐ Gender Non-Conforming (not exclusively male or female)<br>☐ Declined to Respond |
| **Race** | ☐ American Indian/Alaska Native<br>☐ Asian | ☐ Black/African American<br>☐ Native Hawaiian/Pacific Islander | ☐ White<br>☐ Declined to Respond |
| **Additional Race** (Select all that apply) | ☐ African<br>☐ Middle Eastern<br>☐ Slavic | **Ethnicity** | ☐ Non-Hispanic/Non-Latino<br>☐ Hispanic/Latino<br>☐ Declined to Respond |
| **Disability Type** (Select all that apply) | ☐ None<br>☐ Alcohol Abuse<br>☐ Drug Abuse<br>☐ Both Alcohol and Drug Abuse | ☐ Chronic Health Condition<br>☐ Developmental<br>☐ HIV/AIDS | ☐ Hearing Impaired<br>☐ Mental Health<br>☐ Physical<br>☐ Vision Impaired<br><br>☐ Declined to Respond<br>☐ Other: |
| **Health Insurance** (Select all that apply) | ☐ None<br>☐ COBRA<br>☐ Employer Provided | ☐ Medicaid<br>☐ Medicare<br>☐ Indian Health Services Program | ☐ Private Pay<br>☐ SCHIP<br>☐ VA Medical Services<br><br>☐ Declined to Respond<br>☐ Other: |