

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
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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)			
<input type="checkbox"/> Full <input type="checkbox"/> Last 4 digits <input type="checkbox"/> Declined to Respond		SSN: _____ - _____ - _____	
Primary Language:		US Military Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Respond	
Gender <input type="checkbox"/> Female <input type="checkbox"/> Trans Female (Male to Female) <input type="checkbox"/> Gender Non-Conforming (not exclusively male or female)			
<input type="checkbox"/> Male <input type="checkbox"/> Trans Male (Female to Male) <input type="checkbox"/> Declined to Respond			
Race <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> White			
<input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Declined to Respond			
Additional Race (Select all that apply)		Ethnicity	
<input type="checkbox"/> African <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Slavic		<input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to Respond	
Disability Type (Select all that apply)			
<input type="checkbox"/> None <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol and Drug Abuse		<input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> Developmental <input type="checkbox"/> HIV/AIDS	
		<input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Mental Health <input type="checkbox"/> Physical <input type="checkbox"/> Vision Impaired	
		<input type="checkbox"/> Declined to Respond <input type="checkbox"/> Other:	
Health Insurance (Select all that apply)			
<input type="checkbox"/> None <input type="checkbox"/> COBRA <input type="checkbox"/> Employer Provided		<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Private Pay <input type="checkbox"/> SCHIP <input type="checkbox"/> VA Medical Services <input type="checkbox"/> Declined to Respond <input type="checkbox"/> Other:	
Non-Cash Benefits (Select all that apply)			
<input type="checkbox"/> None <input type="checkbox"/> SNAP <input type="checkbox"/> WIC		<input type="checkbox"/> TANF Child Care Services <input type="checkbox"/> TANF Transportation Services <input type="checkbox"/> Other TANF-Funded Services <input type="checkbox"/> Declined to Respond <input type="checkbox"/> 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:	
<input type="checkbox"/> None <input type="checkbox"/> Declined to Respond			
Percent of Median Family Income (Select one option)			
<input type="checkbox"/> 0-30% MFI <input type="checkbox"/> 30-50% MFI <input type="checkbox"/> 50-80% MFI <input type="checkbox"/> Over 80% MFI <input type="checkbox"/> 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	INSTITUTIONAL SITUATION	TRANSITIONAL AND PERMANENT HOUSING SITUATION
<input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter <input type="checkbox"/> Safe Haven	<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in a friend’s room, apartment or house <input type="checkbox"/> Staying or living in a family member’s room, apartment or house <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with VASH subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with other ongoing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> 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 <input type="checkbox"/> Child <input type="checkbox"/> Spouse or Partner <input type="checkbox"/> Other relation member <input type="checkbox"/> Non-relation member																					
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OTHER ADULT (18+ years of age) Data (2 of 2)

Residence Prior to Project Entry

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<p>Length of Stay in Previous Residence (Select one option. “Previous Residence” is the location marked as “Residence Prior...” above):</p>	<input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Declined to Respond	<p>Answer this question if residence prior to program entry is:</p> <ul style="list-style-type: none"> - a homeless situation OR - an institutional situation for less than 90 days OR - a permanent or transitional situation for less than seven days. <p>Otherwise, skip to next page.</p> <p>Did you stay on the streets or in shelter the night before? (Select one option)</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Respond
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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.

<p>Number of times homeless in the last three years (Select one option)</p>	<input type="checkbox"/> One time <input type="checkbox"/> Two times <input type="checkbox"/> Three times <input type="checkbox"/> Four or more times <input type="checkbox"/> Declined to Respond	<p>Approximate date current period of homelessness started (MM/DD/YYYY) _____</p> <hr/> <p>Total number of months homeless in the last three years (Select one option)</p> <input type="checkbox"/> Less than 12 months Number of months: _____ <input type="checkbox"/> 12 or more months
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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	
		<input type="checkbox"/> Child	<input type="checkbox"/> Other relation member
		<input type="checkbox"/> Spouse or Partner	<input type="checkbox"/> Non-relation member
Social Security Number (SSN) (Please indicate how much of your SSN you are willing to share)			
<input type="checkbox"/> Full		<input type="checkbox"/> Last 4 digits	
<input type="checkbox"/> Declined to Respond		SSN: ____ - ____ - _____	
Primary Language:			
Gender			
<input type="checkbox"/> Female	<input type="checkbox"/> Trans Female (Male to Female)	<input type="checkbox"/> Gender Non-Conforming (not exclusively male or female)	
<input type="checkbox"/> Male	<input type="checkbox"/> Trans Male (Female to Male)	<input type="checkbox"/> Declined to Respond	
Race			
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Black/African American	<input type="checkbox"/> White	
<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Declined to Respond	
Additional Race (Select all that apply)		Ethnicity	
<input type="checkbox"/> African	<input type="checkbox"/> Middle Eastern	<input type="checkbox"/> Non-Hispanic/Non-Latino	
<input type="checkbox"/> Slavic		<input type="checkbox"/> Hispanic/Latino	
		<input type="checkbox"/> Declined to Respond	
Disability Type (Select all that apply)			
<input type="checkbox"/> None	<input type="checkbox"/> Chronic Health Condition	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Declined to Respond
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Developmental	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Other:
<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Physical	
<input type="checkbox"/> Both Alcohol and Drug Abuse		<input type="checkbox"/> Vision Impaired	
Health Insurance (Select all that apply)			
<input type="checkbox"/> None	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Private Pay	<input type="checkbox"/> Declined to Respond
<input type="checkbox"/> COBRA	<input type="checkbox"/> Medicare	<input type="checkbox"/> SCHIP	<input type="checkbox"/> Other:
<input type="checkbox"/> Employer Provided	<input type="checkbox"/> Indian Health Services Program	<input type="checkbox"/> VA Medical Services	