HH : (S)_______ - (A)_______ - (C)_______

Collier CRN

Date: ____________________
mm / dd / yyyy

CRN Intake Form

SP# : ____________________
Primary Client

Client Information

Name: ____ **DOB**: _____ / _____ / _______
(First) (Middle) (Last) *mm / dd / yyyy*

Social Security No.: ______ - ____ - ________ **Gender:** Male Female Transgender **Ethnicity:** Hispanic Yes / No

Race: African American Alaskan Native American Indian Asian Pacific Islander White Other: __________

Address: ____ **Apt/Unit #:** ______________

City: __________________________ **County:** _______________ **Zip code:** ___________ **Phone:** ______ - ______ - _______
Area Code 123 4567

Demographics and Housing

U.S. Citizen: Yes No **Marital Status:** Married Single Widowed Divorced Separated **Veteran:** Yes No

Domestic Violence victim/survivor: Yes No **Disability Status:** Yes No **If disabled, for how long:** ___________

If disabled, what type: Physical Mental Medical Substance Abuse Dual Diagnosis

Housing Status: Homeless Imminently losing house Unstably house Stably housed

Duration of housing status: _________ day(s) / week(s) / month(s) / year(s)

Type of Living Situation: Own Renting **Subsidy:** Yes No

Other: ______________________________

If Homeless, how many times in the past 3 years: _________

HUNGER & HOMELESS COALITION OF COLLIER COUNTY

Income: Yes No **If yes, monthly amount:** ___________

Receive Food Stamps: Yes No **If yes, monthly amount:** ___________

Income Type: Wages Unemployment TANF Social Security SSDI SSI Child Support Financial Support Family/Friends

Expenses:

Rent/Mortgage:______________ Electric: ____________ Water: ___________ Phone: ___________

Car Payment/Insurance: ________________ Food: ______________ Other: ____________, $_____________

Other Household Members

Name: _______________________________ **DOB**: _____ / _____ / _______ **Relationship:** ______________

Social Security No.: ______ - ____ - ________ **Gender:** Male Female Transgender **Ethnicity:** Hispanic Yes / No

Race: ______________ **U.S. Citizen:** Yes No **Income:** _____________ / month **Income Type:** _______________

Veteran: Yes No **Disability Status:** Yes No **If yes, for how long:** ____________ **type:** ________________

Name: _______________________________ **DOB**: _____ / _____ / _______ **Relationship:** ______________

Social Security No.: ______ - ____ - ________ **Gender:** Male Female Transgender **Ethnicity:** Hispanic Yes / No

Race: ______________ **U.S. Citizen:** Yes No **Income:** _____________ / month **Income Type:** _______________

Veteran: Yes No **Disability Status:** Yes No **If yes, for how long:** ____________ **type:** ________________

Name: _______________________________ **DOB**: _____ / _____ / _______ **Relationship:** ______________

Social Security No.: ______ - ____ - ________ **Gender:** Male Female Transgender **Ethnicity:** Hispanic Yes / No

Race: ______________ **U.S. Citizen:** Yes No **Income:** _____________ / month **Income Type:** _______________

Veteran: Yes No **Disability Status:** Yes No **If yes, for how long:** ____________ **type:** ________________

Disclaimer: By filling out this application in no way is this a condition to receive USDA commodities.

Turn page over ⇨ ⇨

Other Household Members

Name: ______________________________ **DOB**: _____ / _____ / _______ **Relationship:** __________________
Social Security No.: ______ - ____ - ________ **Gender:** Male Female Transgender **Ethnicity:** Hispanic Yes / No
Race: ______________ **U.S. Citizen:** Yes No **Income:** _____________ / month **Income Type:** _______________
Veteran: Yes No **Disability Status:** Yes No **If yes, for how long:** ____________ **type:** _____________________

Name: ______________________________ **DOB**: _____ / _____ / _______ **Relationship:** __________________
Social Security No.: ______ - ____ - ________ **Gender:** Male Female Transgender **Ethnicity:** Hispanic Yes / No
Race: ______________ **U.S. Citizen:** Yes No **Income:** _____________ / month **Income Type:** _______________
Veteran: Yes No **Disability Status:** Yes No **If yes, for how long:** ____________ **type:** _____________________

Name: ______________________________ **DOB**: _____ / _____ / _______ **Relationship:** __________________
Social Security No.: ______ - ____ - ________ **Gender:** Male Female Transgender **Ethnicity:** Hispanic Yes / No
Race: ______________ **U.S. Citizen:** Yes No **Income:** _____________ / month **Income Type:** _______________
Veteran: Yes No **Disability Status:** Yes No **If yes, for how long:** ____________ **type:** _____________________

Release of Information

Client acknowledges use of and gives permission to this agency to use their personal information in the CRN (Community Resource Network)/ data base. No unaccompanied youth shall have an ROI unless they are 18 years of age or have consent of a parent/guardian. This Release of Information will be used for purposes of accessing services throughout Collier County. Client further testifies that all information given on this Intake Form is true and complete to the best of their knowledge.

I authorize as a CRN Member Agency, to share my basic identifying information and non-confidential service information with other CRN Member agencies. I authorize that a copy of this original will serve as an original for the purposes stated above. Unless I make a formal request to a CRN Member Agency that I no longer want to participate in the CRN, this release will remain enforce for 2 years from today signed date.

Client Signature: ____ **Date:** ____________________

Intake Coordinator Signature: ______________________________ **Date:** ____________________

** *Official Use Only* **

Staff Verification of I.D: ☐ Yes ☐ No

Food Stamp Verification: ☐ Yes ☐ No

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