HOMELESS HEALTH CARE LOS ANGELES
INTAKE FORM

STAFF: _____

INTAKE DATE: _____

PERSONAL INFORMATION

Name: _____ **D.O.B.**_____

Phone # where you can be reached: _____

Mailing address: _____

_____

Birthplace: _____

Date arrived in L.A. County: _____

REFERRAL INFORMATION

Referred by:

_____

Agency **Contact** **Phone #**

Are you working with any other agencies? Yes ☐ No ☐

_____

Agency **Contact** **Phone #**

_____

Agency **Contact** **Phone #**

Are you on probation/parole? Yes ☐ No ☐

Office: _____

Address: _____

_____

Contact: _____**Phone:** _____

RESOURCES

Circle Type of Identification: Drivers License, CA ID Card, Medi-Cal Card, Birth Certificate, Other

Is client receiving public assistance? Yes ☐ No ☐

Specify Type: _____

Date last rec'd: _____ **Amount:** _____

DPSS, Vet., SSI Office: _____

Address: _____

Are you experiencing any problems with your benefits?

Indicate:_____

_____

_____

_____

FAMILY INFORMATION

Spouse/Partner: _____

Sex: ☐ Male ☐ Female

Child's Name **D.O.B.** **Sex** **w/Mom/Dad/Other?**

_____

_____

_____

_____

_____

_____

Do you have an open DCFS case? Yes ☐ No ☐
Office: _____

Address: _____

Worker: _____ **Phone #** _____

Do you have childcare arrangements? Yes ☐ No ☐

Do you plan to participate in childcare? Yes ☐ No ☐

EMERGENCY CONTACT

Name:

_____

Address:

_____

_____

Phone # _____ **Relationship:** _____

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