

CORPUS CHRISTI HOPE HOUSE

CLIENT INTAKE/APPLICATION

Applicant Information:

Today's date _____ Literally Homeless _____ At Risk of Homelessness _____ Veteran Y / N

First Name: _____ Last Name: _____

Phone #: _____ Referred by: _____ Email: _____

Social Security #: _____ Date of Birth: _____ Age: _____

City & State of Birth: _____

Driver's License/ID #: _____ State: _____ EXP. Date: _____

Gender: M / F Marital Status: _____ Religion: _____

Emergency Contact:

Name: _____ Address: _____

City/ZIP: _____ Phone #: _____

Relationship: _____

Ethnicity:

White _____ Hispanic _____ Black _____ Asian _____ Native American _____ Hawaiian/Pacific Islander _____

Other: _____

Place of Residency (Last Night)

Name: _____ Address: _____

City: _____ Phone #: _____

Family Information:

How many individuals live with you? _____ (Please list all children with you below)

Name _____ Age _____ DOB _____ SS# _____ Name of School/Daycare

1. _____

2. _____

3. _____

4. _____

List number of children not living with you: _____ Insurance Coverage: Private / Medicaid / HTW

Are you currently pregnant? YES / NO

Doctor:

Name: _____ Phone: _____

Last Dr appointment: _____ Next appointment: _____

Weeks/Months pregnant: _____ Due date: _____ Gender: F / M

Any complications with pregnancy? YES / NO

Name of hospital: _____

Who will take you to hospital? _____

Where will you leave your other child(ren)? _____

Father of the baby:

Name: _____ Does he know about this pregnancy? YES / NO

Address: _____ City/ZIP: _____

Employment:

Employer: _____ Work Ph#: _____

Address: _____

Education:

High School Graduate? YES / NO If yes, name of school: _____

(copy needed)

G.E.D.? YES / NO If yes, where from: _____

(copy needed)

College/Vocational? YES / NO If yes, where from: _____

Income/Non-Cash:

Sources of Income	Weekly	Biweekly	Monthly	\$ Amount
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Wages	_____	_____	_____	_____
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SSI/SSDI	_____	_____	_____	_____
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Child Support	_____	_____	_____	_____
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Food Stamps	_____	_____	_____	_____
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TANF	_____	_____	_____	_____
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Medical (circle all that apply):

Hope House needs to know medical information and the health standards of all our clients, including prescription drugs prescribed for all members of the family.

Do you have any disabilities? YES / NO

Physical _____ Mental _____

Aids Contagious Diseases Venereal Disease Diabetes Asthma Allergies Blood
Pressure Depression Hepatitis C TB Other

List of Medications:

None of the above:

List any drug counseling program, parenting classes, MHMR counseling or any program you have an open case with.

- 1. _____
- 2. _____
- 3. _____

Special Needs _____ Drug/Alcohol Abuse _____ Read & Write _____
Mental Disorder _____ Attention Deficit _____ PTSD _____

List Medications:

None of the above:

Criminal Record (circle all that apply)

Outstanding Warrants Traffic Felony Convictions Drug Abuse Child Abuse Theft DWI
Parole/Probation Fraud Identity Theft Assault N/A

Explain: _____

Name of Probation Officer: _____ Phone: _____

Do you have a case with child Protective Services? YES / NO

If yes, what is the reason?

Name of CPS Worker: _____ Phone: _____