# Case Management Intake and Assessment Form

**Client Information**

Client Name:

Service Point #:

Date:

Last Address:

How long here?

Age:

DOB: /\_ /\_

SSN:

Cell Phone #:

Race:

Ethnicity: Hispanic or Latino *or* Non-Hispanic or Non-Latino

Emergency Contact(s):

Relationship:

Phone #:

DL or ID? Y N Birth Certificate? YNSS Card? YN How long have you been homeless?

What is your current marital status? :

Anyone here with you? Yes:

* No

Do you have children with you: Yes If yes, List Below No

Name:

Age:

DOB:

Gender:

SSN:

Name:

Age:

DOB:

Gender:

SSN:

Name:

Age:

DOB:

Gender:

SSN:

Name:

Age:

DOB:

Gender:

SSN:

**Veteran Information**

Are you a veteran? Yes No

Copy of your DD214: YesNoDischarge Status: HonorableDishonorable Military benefits in past? Yes No 

**Education**

Highest level of education completed? Special education, behavioral problems or disabilities? Yes No 

**Employment**

Are you working? Yes No Where?: Wage: Temp Permanent What was your last job? When? Reason for leaving? What type of work experience do you have? Have you ever been fired? Yes No When: Reason: Have you applied for any jobs recently? Yes No Where: Physical limitations? Yes No What: Mental health /substance abuse affected work? Yes No

**Legal**

Have you ever been convicted of a crime? Yes No Are you on probation? Yes No

What? When was this? Jail/Prison? Yes No Do you have any legal actions pending currently? Yes No

What? When was this?

|  |  |
| --- | --- |
| **Income and Resources****Are you receiving any of the following?*** SSI(Child)
* SSI/SSDI/Retirement
* FIP (TANF)

Child Support * Alimony/spousal support
* Employment
* Unemployment
* Disability/Work Comp
* Pension
* Medicaid or Medicare
* Food Stamps or WIC
* Section 8, public housing or ongoing rental assistance
* TANF Child Care, Transportation, Other
* VA Medical, Iowa Care, MH/DS
 | **Debts/Financial Responsibilities****Do you have to pay on the following in the next 90 days?*** Credit card(s)
* Loans(s)
* Past due rent
* Cell phone
* Vehicle
* Utility bills
* Child support
* Court fees or fines
* Storage units
* Other
 |
|  |  |  |
|  |  |  |
|  |  |  |

**Physical Health**

Do you have access to health care? Yes No Any current health concerns/diagnosis? Yes No

Do you take any medications? Yes No

Do you need any refills on medications? Yes No

Pregnant? Yes Due date: \_ No Physical limitations? Yes No

Do you need referrals for HIV/AIDS/Hepatitis testing or services? Yes No

Do you need glasses? Yes No Hearing loss or difficulty? Yes No Allergies: Yes No

**Mental Health**

Have you ever been seen by someone for mental health? Yes No If yes, your diagnosis:

Have you had any inpatient treatments? Yes No

Have you had outpatient treatments? Yes No

Any current treatment? Yes No If no, would you like to be seen? Yes No

**Case Manager: Complete additional Mental Health and Wellness Form**

**Substance Abuse**

Have you ever used drugs or alcohol? Yes No

If yes, list type and date last used:

Inpatient Treatment? Yes No

Outpatient? Yes No

Current Yes No

Clean UA today? Yes No

**Case Management**

Is there anything else I should know about you and/or your family? Yes No

## Client Signature:

Date:

Case Manager Signature:

Date: