

## Appendix D

# HOSPITALITY IN THE NAME OF CHRIST GUEST INTAKE

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Suffix \_\_\_\_\_

Date of Birth \_\_\_\_\_ (mm/dd/yyyy) SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Status  Single  Married  Separated  Divorced  Widowed  Other

### Gender

- Female
- Male
- Transgender
- Unknown

### Ethnicity

- Hispanic/Latino
- Other (Non-Hispanic/Latino)

### Primary Race

- American Indian or Alaskan Native
- Native Hawaiian or other Pacific Islander
- Asian
- Black or African American
- White
- Other
- Other Multi-racial

### Secondary Race (if applicable)

- American Indian or Alaskan Native
- Native Hawaiian or other Pacific Islander
- Asian
- Black or African American
- White
- Other
- Other Multi-racial

Do you have a history of any sexual and/or assaultive offenses? Yes  No

Are you required to register as a sex offender? Yes  No

Do you have any allergies? Yes  No  If yes, what? \_\_\_\_\_

Are you currently being treated for any medical condition? Yes  No

If yes, for what? \_\_\_\_\_

Are you currently taking any medications? Yes  No  If yes, what? \_\_\_\_\_

If yes, why? \_\_\_\_\_

Do you have any open sores or wounds? Yes  No  Do you need immediate medical attention? Yes  No

Do you have medical insurance/coverage? Yes  No

### Is Guest Homeless?

- Yes
- No

### Is Guest Chronically Homeless?

- Yes
- No

### Prior Living Situation

- Don't Know
- Foster care/group home
- Other
- Refused
- Owns House/Apartment
- Rental House/Apartment
- Jail, Prison or Juvenile Facility
- Domestic Violence Situation
- Hospital

- Emergency Shelter
- Living with Family
- Living with Friends
- Place not meant for habitation
- Psychiatric Hospital or Facility
- Substance Abuse Treatment Center
- Subsidized Housing
- Transitional Housing for Homeless
- Hotel/Motel without emergency shelter

### What do you feel is your primary reason for your current situation?

- Alcohol and/or Drug Use
- Separation/Divorce
- Eviction
- Dispute with Family/Friends
- Unemployment/Loss of Income
- Substandard Housing
- Domestic Violence
- Veteran
- Lost Benefits from SSI/SSDI/VA
- Lost Public Assistance – DHS/Food Stamps
- Mortgage Foreclosure
- No Affordable Housing
- Physical Disabilities
- Mental Health Condition
- Medical Condition
- Other (describe): \_\_\_\_\_

**Length of Stay at Shelter?**

- One week or less
- More than one week, but less than one month
- One to three months
- More than three months, but less than one year

**Actual or Pending Eviction?**

- Yes
- No

**Actual or Pending Foreclosure?**

- Yes
- No

**Zip Code of Last Permanent Address** \_\_\_\_\_

**Zip data quality**

- Full Zip Code Recorded
- Don't Know
- Refused

**US Military Veteran**

- Yes
- No
- Don't Know
- Refused

**Do you have a disability of long duration?**

- Yes
- No
- Don't Know
- Refused

**Disability Sub-assessment**

- |   |                  |                |                                    |
|---|------------------|----------------|------------------------------------|
| <input type="checkbox"/> Alcohol Abuse            | start date _____ | end date _____ | <input type="checkbox"/> long term |
| <input type="checkbox"/> Developmental            | start date _____ | end date _____ | <input type="checkbox"/> long term |
| <input type="checkbox"/> Drug Abuse               | start date _____ | end date _____ | <input type="checkbox"/> long term |
| <input type="checkbox"/> Physical/Medical         | start date _____ | end date _____ | <input type="checkbox"/> long term |
| <input type="checkbox"/> Mental Illness           | start date _____ | end date _____ | <input type="checkbox"/> long term |
| <input type="checkbox"/> Physical/Mobility Limits | start date _____ | end date _____ | <input type="checkbox"/> long term |
| <input type="checkbox"/> HIV/AIDS                 | start date _____ | end date _____ | <input type="checkbox"/> long term |
| <input type="checkbox"/> Hearing Impaired         | start date _____ | end date _____ | <input type="checkbox"/> long term |
| <input type="checkbox"/> Vision Impaired          | start date _____ | end date _____ | <input type="checkbox"/> long term |
| <input type="checkbox"/> Dual Diagnosis           | start date _____ | end date _____ | <input type="checkbox"/> long term |
| <input type="checkbox"/> Other                    | start date _____ | end date _____ | <input type="checkbox"/> long term |

**Describe your current income, if any:**

- |   |   |
|---|---|
| <input type="checkbox"/> Full-time Employment | <input type="checkbox"/> Part-time Employment         |
| <input type="checkbox"/> Day Labor            | <input type="checkbox"/> Unemployment Benefits        |
| <input type="checkbox"/> SDA/DHS              | <input type="checkbox"/> No Income                    |
| <input type="checkbox"/> SSI/SSD              | <input type="checkbox"/> Other, Please Specify: _____ |

**Which of the following best describes your current employment situation?**

- |   |  |
|---|--|
| <input type="checkbox"/> Day Labor at least 2 days a Week | <input type="checkbox"/> Regular Full-time     |
| <input type="checkbox"/> Looking for Work                 | <input type="checkbox"/> Regular Part-time     |
| <input type="checkbox"/> Temporary/Seasonal Full-time     | <input type="checkbox"/> Supportive Employment |
| <input type="checkbox"/> Unable to Work                   | <input type="checkbox"/> Other: _____          |

**Why do you think you are unable to obtain employment?**

- |   |   |
|---|---|
| <input type="checkbox"/> Alcohol and/or Drug Use      | <input type="checkbox"/> Domestic Violence                |
| <input type="checkbox"/> Learning Disability          | <input type="checkbox"/> Chronic Medical Condition        |
| <input type="checkbox"/> Need for job training/skills | <input type="checkbox"/> Criminal History                 |
| <input type="checkbox"/> Language Barriers            | <input type="checkbox"/> Physical Disability              |
| <input type="checkbox"/> Lack of Transportation       | <input type="checkbox"/> Severe/Persistent Mental Illness |
| <input type="checkbox"/> Developmental Disability     | <input type="checkbox"/> Other, Please Specify: _____     |

**Emergency:**

Who can we contact in case of emergency? (Please Provide Name, Relationship, and Phone Number)

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