

## Supportive Housing Client Intake Form

GATLING ESTATES LLC

Participant Intake & Enrollment Application

Date of Intake: \_\_\_\_\_



Referral Agency/ Name of Referrer: \_\_\_\_\_

### Participant Information

- Full Name: \_\_\_\_\_
- Date of Birth: \_\_\_\_\_
- Age: \_\_\_\_\_
- Social Security Number (Last 4 digits): \_\_\_\_\_
- Phone Number: \_\_\_\_\_
- Email Address: \_\_\_\_\_
- Gender:  Male  Female  Non-binary  Prefer not to say
- Emergency Contact Name: \_\_\_\_\_
- Relationship: \_\_\_\_\_
- Emergency Contact Phone: \_\_\_\_\_

### Current Living Situation

- Homeless
- Couchsurfing / Staying with others
- Transitional Housing
- Jail/Prison Release
- Hospital / Rehab
- Other: \_\_\_\_\_

### Referral Source (If Applicable)

- Self
- Agency: \_\_\_\_\_
- Parole/Probation
- Hospital or Treatment Center
- Family/Friend
- Referring Contact Name: \_\_\_\_\_
- Phone/Email: \_\_\_\_\_

### Brief Summary of Situation / Reason for Housing Need

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**Medical & Mental Health History (List Below)**

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**Mental health diagnosis (if any):**

- Substance use history (if any):  
 Alcohol  Drugs  None  
If yes, explain: \_\_\_\_\_

**Legal Background**

- Are you currently on parole or probation? (**List PO Name/Phone Number**)  
 Yes  No
- Are you a registered sex offender?  
 Yes  No
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**Income Information**

- Do you have a source of income?  
 Yes  No  
 SSI  SSDI  Employment  Other: \_\_\_\_\_
- Monthly Income Amount (if any): \$ \_\_\_\_\_

**Housing Preferences or Needs**

- Any disabilities or accommodations needed?  
 Yes  No — If yes, explain: \_\_\_\_\_
- Preferred Room Type:  
 Shared Room  Private Room (if available)

**Independent Living & Functionality Acknowledgment**

Our program is designed for individuals who are high-functioning and capable of living independently. This is not a personal care home, nursing home, or assisted living facility. We do not provide medical care, personal assistance, or supervision.

You must be able to manage your own:

- **Personal hygiene and grooming**

- **Meal preparation and eating**
- **Medication (unless managed by an outside provider)**
- **Mobility and transportation arrangements**
- **Housekeeping and laundry**
- **Daily living responsibilities**

If you require medical or personal care services, they must be provided by a licensed outside agency or caregiver, arranged and paid for separately.

Can you live independently and manage your Activities of Daily Living (ADLs) without assistance?

Yes

No – Please explain: \_\_\_\_\_

Do you currently have or need a home health care provider or outside support service?

Yes – Agency Name (if applicable): \_\_\_\_\_

No

I understand and agree that this program provides housing only. I will be responsible for my personal care, medical needs, and daily living tasks. I will not hold the program responsible for services outside the scope of independent housing.

Participant Initials: \_\_\_\_\_ Date: \_\_\_\_\_

### **Program Agreement Preview**

I understand that if accepted, I must follow all house rules, expectations, and participate in case management or program-related check-ins.

I acknowledge that violating rules may result in a strike or dismissal from the program.

### **Applicant Declaration**

I certify that the above information is true to the best of my knowledge. I understand that this intake does not guarantee placement, and my application will be reviewed by staff.

Participant Name: \_\_\_\_\_

Participant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Staff Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_