

# GRIER HOUSE PARTICIPANT INTAKE FORM

## PARTICIPANT IDENTIFICATION

Full Legal Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Last 4 digits of SSN: \_\_\_\_\_

Gender:  Male  Female  Non-binary  Prefer not to say

Marital Status:  Single  Married  Divorced  Widowed

Primary Language: \_\_\_\_\_

## CURRENT HOUSING INFORMATION

Current Address (if applicable): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Current Living Situation:

Homeless/Shelter  Family/Friends  Transitional Housing  Reentry

Other: \_\_\_\_\_

## REFERRAL INFORMATION

Referred to program?  Yes  No

Referral Source / Agency: \_\_\_\_\_

Contact Person & Phone: \_\_\_\_\_

## EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

**INCOME INFORMATION**

Do you have income?  Yes  No

Source(s):  Employment  SSI  SSDI  VA  Other: \_\_\_\_\_

Approx. Monthly Income: \$ \_\_\_\_\_

**IDENTIFICATION DOCUMENTS**

State ID  SS Card  Birth Certificate  Insurance Card  Proof of Income

Missing Documents (if any): \_\_\_\_\_

**LEGAL / SUPERVISION STATUS**

Currently under supervision?  Yes  No

Type:  Probation  Parole  Court  Other: \_\_\_\_\_

Officer / Agency & Phone: \_\_\_\_\_

**MEDICAL HISTORY & HEALTH DISCLOSURE**

This information is collected for emergency preparedness only. The program does not provide medical or personal care services.

Do you have medical conditions affecting independent living?

Yes  No

If yes (optional): \_\_\_\_\_

Chronic Conditions (check all that apply):

Diabetes  Heart Condition  Asthma  Seizures  Mobility Issues  Other: \_\_\_\_\_

Mental Health Disclosure (optional):  Yes  No  Prefer not to answer

Currently receiving treatment?  Yes  No

Prescribed Medications?  Yes  No

Medication Name | Prescribed By | Self-Administered

\_\_\_\_\_

Allergies:  None  Food  Medication  Environmental  Other: \_\_\_\_\_

**PROGRAM ACKNOWLEDGEMENTS**

- \_\_\_\_\_ I understand this is an independent living housing program.
- \_\_\_\_\_ I understand no medical or personal care services are provided.
- \_\_\_\_\_ I understand occupancy is not a lease.
- \_\_\_\_\_ I agree to follow program rules and guidelines.

**PARTICIPANT CERTIFICATION**

I certify that the information provided is true and accurate.

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

Printed Name: \_\_\_\_\_

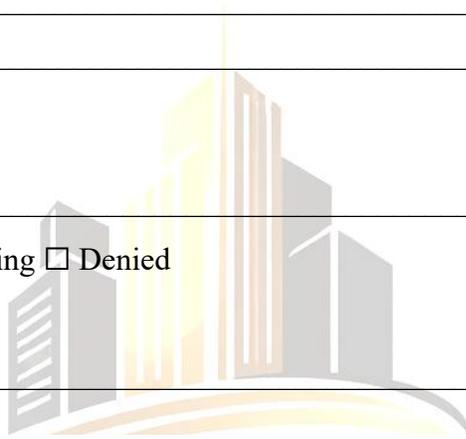
**STAFF USE ONLY**

Intake Completed By: \_\_\_\_\_

Eligibility:  Approved  Pending  Denied

Notes:

\_\_\_\_\_



**GRIER**  
— HOLDINGS LLC —