



INDEPENDENT HOUSING CLIENT INTAKE FORM

THE RAINBOW BUTTERFLY FOUNDATION LLC

Participant Intake & Enrollment Application

Date of intake: _____ **Referral Agency:** _____

Case Manager _____

Company _____

Phone _____

Email _____

1. Participant Information

- Full Name: _____
- Date of Birth: _____ Age: _____
- Last 4 of SSN: _____ Gender: [] Male [] Female [] Non-binary [] Prefer not to say
- Phone Number and Email Address: _____

2. Emergency Contact Information

- Emergency Contact Name: _____
- Emergency Contact Phone: _____
- Relationship: _____

3. Current Living Situation

- [] Unhoused (Homeless)
- [] Couch-surfing/Staying with others
- [] Transitional Housing
- [] Jail/Prison Release
- [] Hospital/Rehab
- [] Other _____

4. Referral Source (if applicable)

- [] Self
- [] Agency: _____
- [] Parole/Probation Referring Contact Name: _____
- [] Hospital/Treatment Center Phone/Email: _____
- [] Family/Friend

5. Brief Summary of Situation/Reason for Housing Need



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6. Medical & Mental Health History (please list below)

-
-
-
-
-

Mental health diagnosis (if any): _____

7. Substance Use/Abuse History (if any):

Alcohol Drugs Prescribed Pills Other None

If yes, explain: _____

8. Legal Background

- Are you currently on parole or probation? Yes No
- Are you a registered sex offender? Yes No
- Probation/Parole Officer Information (if applicable) _____

9. Income Information

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

10. Housing Preference or Needs

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

Independent Living & Functionality Agreement

Our program is designed for individuals who are high-functioning and capable of living independently. This is NOT a personal care home, nursing home, group 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 - if NO, please explain: _____



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

Yes No - if yes, Agency Name: _____

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 living.

Participant Initials: _____ Date: _____

Program Agreement

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 program participation is month-to-month and violating rules may result in a strike and/or immediate 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: _____

Staff Signature: _____ Date: _____