

Catholic Charities CYO
 Scattered Sites
 Shelter Plus Care
CLIENT INTAKE FORM

FOR OFFICAL USE ONLY

Status: New Repeat
 ID#: _____
 Case Manager: _____
 Date Opened: _____

Last Name: _____ First: _____ M/O: _____

Current Address: _____ City/State/Zip: _____

Telephone: Home: _____ Work: _____ Cell, Beeper or Message: _____

MARITAL STATUS *circle one*

Single Boyfriend Girlfriend Common Law
 Registered Domestic Partner Married Separated Divorced Widowed

EMERGENCY INFORMATION

Emergency Contact: _____ Telephone: _____

A. HOUSEHOLD

Is applicant? (circle all that applied) Disabled ADA Certified Disability (see page 4)

Is any family member pregnant? *circle one* Yes No

If yes, name: _____ Expected delivery date: _____

Lead Applicant (Head of Household-Lease Holder)

How many people will live with you? (including caregiver if applicable) # _____

Last Name: _____ First: _____ M/O: _____

DOB: *Circle One* Female Male SS#

Asian Black/African American Latino Native American Pacific Islander White/Anglo Other: _____

Secondary Applicant (Spouse, partner, adult child, or Caregiver etc.)

Last Name: _____ First: _____ M/O: _____

DOB: *Circle One* Female Male SS#

Asian Black/African American Latino Native American Pacific Islander White/Anglo Other: _____

List all children (all children of lead and secondary lease holder, living with, in reunification or other living situation)

Last Name: _____ First: _____ M/O: _____

DOB: *Circle One* Female Male SS#

Asian Black/African American Latino Native American Pacific Islander White/Anglo Other: _____

A. HOUSEHOLD (continued)

Last Name: _____ First: _____ M/O: _____
DOB: *Circle One* Female Male SS#
Asian Black/African American Latino Native American Pacific Islander White/Anglo Other: _____

Last Name: _____ First: _____ M/O: _____
DOB: *Circle One* Female Male SS#
Asian Black/African American Latino Native American Pacific Islander White/Anglo Other: _____

Last Name: _____ First: _____ M/O: _____
DOB: *Circle One* Female Male SS#
Asian Black/African American Latino Native American Pacific Islander White/Anglo Other: _____

Last Name: _____ First: _____ M/O: _____
DOB: *Circle One* Female Male SS#
Asian Black/African American Latino Native American Pacific Islander White/Anglo Other: _____

B. INCOME (LEAD RESIDENT)

1. Monthly Income Source (*circle all that apply and fill-in amounts*)

Paid Work\$ _____ TANF/AFDC \$ _____ GA \$ _____
SSDI \$ _____ SSI \$ _____ Soc. Sec \$ _____
Unemployment \$ _____ Child Support \$ _____ VA Benefits \$ _____ Other: \$ _____
Food Stamps \$ _____ *Specify type* _____
Net Income \$ _____ Gross Monthly Family Income \$ _____

2. Primary Health Care

Medicare Medical Private HMO Public Health Department

B. INCOME (SECONDARY)

1. Monthly Income Source (*circle all that apply and fill-in amounts*)

Paid Work\$ _____ TANF/AFDC \$ _____ GA \$ _____
SSDI \$ _____ SSI \$ _____ Soc. Sec \$ _____
Unemployment \$ _____ Child Support \$ _____ VA Benefits \$ _____ Other: \$ _____
Food Stamps \$ _____ *Specify type* _____
Net Income \$ _____ Gross Monthly Family Income \$ _____

2. Primary Health Care

Medicare Medical Private HMO Public Health Department

C. HISTORY OF HOMELESSNESS

1. When did you become homeless?

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How long were you homeless before you entered the DHS or SFHA program? (specify, in days, months, and years) _____

2. Are you currently homeless? YES NO

3. What was your living situation? (circle those that apply, no more than 2)

- | | | |
|-----------------------------|---------------------------|------------------------|
| Street/Car | Emergency Shelter | Transitional Housing |
| SRO/Hotel | Permanent | Hospital/Hospice |
| Living with relative/friend | Domestic Violence Shelter | Recovery Program |
| Mental Health in-patient | Incarceration | Other: (specify) _____ |

CURRENT HOUSING SITUATION

How long have you been in a housing program? (specify, in days, months, and years) _____

2. What is your current living situation? (circle those that apply, no more than 2)

- | | | |
|-----------------------------|---------------------------|--------------------------|
| Street/Car | Emergency Shelter | Transitional Housing |
| SRO/Hotel | Permanent | Hospital/Hospice |
| Living with relative/friend | Domestic Violence Shelter | Recovery Program |
| Mental Health in-patient | Incarceration | Other subsidized housing |
| Market Rate | Market Rate w/roommate | Home Ownership |
| Section 8 | Public Housing | Other: _____ |

Total # of people living in home? _____ # of bedrooms _____ Total monthly rent \$ _____

Behind in rent? (circle one) YES NO If Yes, how much do you owe? _____

Eviction Status (circle one)

- Verbal Warning Written Notice 3 Day or Quit Sheriff's Notice Unlawful Detainer

NOTICE OF RIGHT TO REASONABLE ACCOMMODATIONS

If you have a physical or mental disability, and as a result of this disability you need:

- **A change or repair in your apartment** that would give you an equal chance to live here and benefit from the use of your apartment

EXAMPLES: GRAB BARS LOWERED COAT RACKS FLASHING FIRE ALARM AND DOORBELL

- **A change or repair to some other part of the housing site** that would give you an equal chance to live here and use the facilities or programs on site

EXAMPLES: FRONT-LOADING WASHING MACHINES AN ACCESSIBLE INTERCOM SYSTEM

- **A change in the rules or policies or how we do things** that would give you an equal chance to live here and use the facilities or take part in programs on site

EXAMPLES: ALLOWING SERVICE ANIMALS RENT REMINDERS HELP WITH GARBAGE

- **A change in the way we give you information**

EXAMPLES: BIG PRINT SIGN LANGUAGE INTERPRETER AUDIO-TAPE CAPTIONING

Then you may ask for this kind of change, which is called a **REASONABLE ACCOMMODATION**. What you ask for may be one of the examples listed above, or it may be any other change you need.

If you can show that you have a physical or mental condition that needs this change, and if your request is reasonable (it is not too expensive and not too difficult to arrange), we will try to make the changes you ask for.

You can ask for a Reasonable Accommodation by contacting the Property Manager for Catholic Charities CYO Treasure Island Supportive Housing at John Stewart Property Management Company. S/he may ask you to fill out a Reasonable Accommodation Request form. S/he will help you fill it out, or take your request verbally, if you like.

We will respond in 15 business days unless there is a problem getting the information we need. We will let you know if we need more information or if we need verification from you.¹

Name (print)

Signature

Date

¹ Note: All information you provide will be kept confidential and used only to help you have an equal opportunity to enjoy your housing and the common areas.



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We will respond in 15 business days unless there is a problem getting the information we need. We will let you know if we need more information or if we need verification from you.²

CLIENT COPY

² Note: All information you provide will be kept confidential and used only to help you have an equal opportunity to enjoy your housing and the common areas.

PROPERTY MANAGEMENT SCREENING SHEET

FOR OFFICIAL USE ONLY

Lead Resident Last Name		Lead Resident First Name	
Lead Social Security #		Lead Residents DOB	
CA State ID or Driver's License #			
Housemate's Last Name		Housemate's First Name	
Housemate Social Security #		Housemate's Mate DOB	
Housemate's CA State ID or Driver's License #			

AS FAR BACK AS POSSIBLE

RESIDENT ADDRESS All old addresses, city, state and zip

Street Address		City/State	Zip
<i>Eviction Status (circle if applicable)</i>	Verbal Warning	Written Notice	3 Day or Quit
	Sheriff's Notice	Unlawful Detainer	

Street Address		City/State	Zip
<i>Eviction Status (circle if applicable)</i>	Verbal Warning	Written Notice	3 Day or Quit
	Sheriff's Notice	Unlawful Detainer	

Street Address		City/State	Zip
<i>Eviction Status (circle if applicable)</i>	Verbal Warning	Written Notice	3 Day or Quit
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Street Address		City/State	Zip
<i>Eviction Status (circle if applicable)</i>	Verbal Warning	Written Notice	3 Day or Quit
	Sheriff's Notice	Unlawful Detainer	

D. EDUCATION & EMPLOYMENT HISTORY

Lead Applicant (*Head of Household*)

1. Highest grade completed (*circle one*)

1 2 3 4 5 6 7 8 9 10 11 12 High Graduate GED Undergraduate 1 2 3 4
 Undergraduate Degree *specify* _____ Graduate Degree *specify* _____

2. Vocational Training? YES NO If *Yes*, what vocation? _____

3. Currently Employed YES NO
 If *Yes*, Title: _____ Place of employment _____

If *No*, Last day of employment

--	--	--

 Last place of employment _____
 Title/Type of work _____

Secondary Applicant (*Spouse, partner, adult child, etc.*)

1. Highest grade completed (*circle one*)

1 2 3 4 5 6 7 8 9 10 11 12 High Graduate GED Undergraduate 1 2 3 4
 Undergraduate Degree *specify* _____ Graduate Degree *specify* _____

2. Vocational Training? YES NO If *Yes*, what vocation? _____

3. Currently Employed YES NO
 If *Yes*, Title: _____ Place of employment _____

If *No*, Last day of employment

--	--	--

 Last place of employment _____
 Title/Type of work _____

Indicate the service utilized by the program applicant.

Service	Who: Print Agency Name & Provider Name	Contact Information*:	
		Address	Telephone
<input type="checkbox"/> Outreach			
<input type="checkbox"/> Case Management			
<input type="checkbox"/> Alcohol/Drug			
<input type="checkbox"/> Mental Health			
<input type="checkbox"/> Physical Health (non AIDS related)			
<input type="checkbox"/> General Education			
<input type="checkbox"/> Employment /Vocational Assistance			
<input type="checkbox"/> Child Care			
<input type="checkbox"/> Life Skills			
<input type="checkbox"/> Residential Management Services			
<input type="checkbox"/> AIDS Related Services			
<input type="checkbox"/> Benefits Advocacy			
<input type="checkbox"/> Rep. Payee/ Money Management			
<input type="checkbox"/> Children's Services			
<input type="checkbox"/> Follow-up (post exit)			
<input type="checkbox"/> Other			

OFFICIAL USE ONLY

DHS CLASSIFICATION (circle one):

1. Short Term Stabilization
2. Eviction Prevention
3. Long-term Case Management

PRESENTING NEEDS (circle all that apply)

Counseling	Family Support	Case Management
Security Deposit/Move-in Cost	Back Rent	Permanent Housing
Shelter	Hotel Voucher	Employment
Childcare	Advocacy	Food
Furniture	Emergency Assistance	Other: _____

REFERRED BY (circle one)

Self Advocacy	Friends/Relatives	Outreach
SFHA	Law Enforcement	Mental Health Practitioner
Medical Practitioner	Shelter	Landlord
Recovery (substance/chemical)	Social Service	Church
Supportive Health Services	Homeless Advocate	Other: _____

HUD DISABILITY STATUS (circle applicable status)

1. Severe Mental Illness*
2. Chronic Alcoholism*
3. Long-term Substance Abuse*
4. HIV/AIDS*
5. ADA Disability:
6. Other*: _____

*Multi-diagnosed (any combination of 1 – 4)

Dual Diagnosis

Triple Diagnosis

COMMENTS:

REASON FOR NOT ENTERING PROGRAM (circle all that apply)

Refuse to participate

Not homeless

Did not meet other eligible requirements *specify* _____

No vacancies

Not known

Other *specify* _____

INCOME CERTIFICATION

Last Name: _____ First: _____ M/O: _____

Current Address: _____ City/State/Zip: _____

To qualify for a federal Home Program-funded rental assistance or security deposit grant, you must be a low-income or very low-income person or household. Please look over the following list of qualification and check the one that applies to you:

CHECK ONE ONLY

- I live in a two (2) person household and together we earn less than \$23,850 per year
- I live in a two (2) person household and we earn between \$23,850 and \$31,150 per year

- I live in a three (3) person household and together we earn less than \$26,800 per year
- I live in a three (3) person household and we earn between \$26,800 and \$36,200 per year

- I live in a four (4) person household and together we earn less than \$29,800 per year
- I live in a three (4) person household and we earn between \$29,800 and \$40,200 per year

- I live in a five (5) person household and together we earn less than \$32,200 per year
- I live in a five (5) person household and we earn between \$32,200 and \$43,400 per year

- I live in a six (6) person household and together we earn less than \$34,500 per year
- I live in a six (6) person household and we earn between \$34,500 and \$46,650 per year

- I live in a seven (7) person household and together we earn less than \$36,950 per year
- I live in a seven (7) person household and we earn between \$36,950 and \$49,850 per year

- I live in a eight (8) person household and together we earn less than \$39,350 per year
- I live in a eight (8) person household and we earn between \$39,350 and \$53,050 per year

I certify that this statement is true and correct to the best of my knowledge. I fully understand that it is a Federal crime and punishable by fine or imprisonment, or both, to knowingly make any false statements concerning any of the above facts about my family's income.

Signature

Date

The above information is furnished in strict confidence. Thank you for your cooperation.

FAMILY INCOME, RESOURCES, AND BUDGET ASSESSMENT

Family Name: _____ Date: _____

Lead resident net wages	_____	Rent/Mortgage	_____
Spouse, partner, etc. net wages	_____	PG&E	_____
Other income or wages	_____	Telephone	_____
Child Support	_____	Water	_____
AFDC/TANF	_____	Garbage	_____
GA	_____	Health Insurance	_____
SSA	_____	Child Care/Tuition	_____
SSI	_____	Car Payment/Insurance	_____
Food Stamp	_____	Installment Payments	_____
Other	_____	Food	_____
	_____	Transportation/Gas	_____
Total Monthly Income	\$ _____	Medical Prescriptions	_____
		Laundry/Cleaning	_____
		Clothing	_____
		Cigarettes	_____
		Cable TV/Entertainment	_____
		Toiletries/Personal	_____
		Miscellaneous	_____
		Total Monthly Expenses	\$ _____

BALANCE

Monthly Income \$ _____

Monthly Expenses \$ _____

Monthly Balance \$ _____

Catholic Charities CYO
Treasure Island Supportive Housing

PROGRAM RULES

The following program rules govern my participation in the CCCYO - Treasure Island Supportive Housing Program

I UNDERSTAND THAT IF I PERFORM ANY OF THE FOLLOWING ACTIVITIES, MY RENTAL ASSISTANCE MAY BE TERMINATED.

1. Selling drugs in or near the building, by myself, guest, or family member as witnessed by Police, Program, or Building staff or as documented by five (5) confidential complaints by a tenant or other person(s) on the lease.
2. Committing, threatening to commit, physical violence including domestic violence in the building. Violence or threats of violence by guest or family members will also be considered a violation of this rule.
3. Willfully and/or repeatedly causing disturbance of the quiet enjoyment of the community by myself, guest, or family member as witnessed by Police, Program, or Building staff or as documented by five (5) confidential complaints by a tenant or other person(s) on the lease.
4. Willfully and/or repeatedly causing damage to the physical plant, surroundings or causing health, sanitation, fire or safety hazard. Damage or health/safety hazards caused by guest or family members will also be considered a violation of this rule.

THE CCCYO - TREASURE ISLAND SUPPORTIVE HOUSING PROGRAM PROHIBITS ALL OF THE ABOVE ACTIVITIES.

These rules have been read by or to me prior to my signature below. I understand these rules and I have received a copy of them. If in the future I have any questions about these rules, I can speak with a Peer Advocate, Case Manager, Services Coordinator, Program Manager, or Director.

Head of household Signature
(Program participant)

Date: _____

Print Name
(Program participant)

Secondary Resident Signature
(Program participant)

Date: _____

Print Name
(Program participant)

Program Staff Signature

Print Name

Title

Date: _____

FILE COPY

Catholic Charities CYO
TREASURE ISLAND SUPPORTIVE HOUSING
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CLIENT COPY

LEVEL OF PARTICIPATION

I understand that as a participant in the CCCYO - Treasure Island Supportive Housing program on Treasure Island, I am responsible for participating as prescribed by CCCYO - Treasure Island Supportive Housing guideline set forth by Department of Human Services (DHS) and supported by Catholic Charities CYO Treasure Island Supportive Housing contractual agreement.

The prescribe participation include, but are not limited to:

Meeting with assigned Peer Advocates on a monthly basis; by mutually agreed upon days and times

Participating in Community Events (i.e., holiday parties, group trips and community building events)

Cooperating with, or providing pertinent information relevant to the housing subsidy (i.e., income verification, service delivery, referrals and linkages)

I agree to participate in services enriched CCCYO - Treasure Island Supportive Housing provided by Catholic Charities CYO Treasure Island Supportive Housing (CCCYO-TISH) and its agent John Stewart Company (JSCo)

I fully understand these policies and to the best of ability will cooperate with CC/CYO-ASF. I am aware that these services are voluntary; however, to fully realize my potential around housing and my associated disability, I will utilized the services of CC/CYO-ASF

Signature
(Program participant)

Print Name
(Program participant)

Date: _____

Secondary Resident Signature
(Program participant)

Print Name
(Program participant)

Date: _____

Witnessed by:

Program Staff Signature

Print Name

Title

Date: _____



Treasure Island Supportive Housing
Catholic Charities CYO

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CLIENT COPY



TREASURE ISLAND GRIEVANCE POLICY

The Treasure Island Supportive Housing is a division of Catholic Charities CYO. Catholic Charities CYO Treasure Island Supportive Housing CYO is committed to serving all individuals with respect and courtesy in a professional manner. If an individual feels that he/she has been inappropriately served, that individual is entitled to lodge a grievance with the organization.

The grievance process is as follows:

The customer should **first** address the grievance with the Program Manager of the staff member involved. Please allow the Supervisor 24 hours after receiving the grievance to respond.

If the customer is not satisfied with the Program Manager's response, the grievance should be addressed to the Program Director.

If the customer is not satisfied with the response of the Program Director, the grievance should be addressed to the Operations Director of Family and Children's Services of the organization.

If the customer is not satisfied with the response of the Operations Director of Family and Children Services, the grievance should be addressed to the Executive Director.

If the customer is not satisfied with the response of the Executive Director, the Executive Director will arrange for the customer to present his or her grievance to the appropriate Board committee.

The Board committee's decision in such a grievance is **final**.

If you believe you have been discriminated against, you may contact the San Francisco Human Rights Commission at 415-252-2500.

If you have any questions about the Catholic Charities CYO – Treasure Island Supportive Housing program's Grievance Procedure process, please contact the Program Manager at 415-743-0017.

Head of household Signature
(Program participant)

Date: _____

Print Name
(Program participant)

Secondary Resident Signature
(Program participant)

Date: _____

Print Name
(Program participant)

Witnessed by:

Program Staff Signature

Print Name

Title

Date: _____



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CLIENT COPY



CONSENT TO RELEASE INFORMATION

Last Name: _____ First: _____ M/O: _____
 DOB: SS#

I, _____, hereby authorize and grant my permission to the Treasure Island Supportive Housing program of Catholic Charities CYO to obtain, release and/or exchange **confidential and privileged** information with other agencies and entities as required and applicably appropriate to the coordination of supportive health, mental and social services for my family and me.

I am aware that such information will remain confidential and provisional accessible to Catholic Charities CYO Treasure Island Supportive Housing (CCCYO-TISH), Department of Human Services Shelter + Care Program (DHS), Department of Housing and Urban Development (HUD) and the San Francisco Housing Authority (SFHA) only.

I understand that this CONSENT TO RELEASE INFORMATION is put into effect until such time that it is revoked or terminated in writing to the grantee or grantor.

I further understand with written notice, and my signature affixed to said document, any specific CCCYO-TISH CONSENT TO RELEASE INFORMATION can at anytime be discharged, revoked, or terminated by the person whose name appears above.

Signature
(Program participant)

Print Name
(Program participant)

Date: _____

Witnessed by:

Program Staff Signature

Print Name

Title

Date: _____

AUTHORIZATION FOR EXCHANGE OF INFORMATION

The San Francisco Shelter + Care Program (S+C) is a supportive housing program funded by the Department of Housing and Urban Development (HUD). As a condition of funding, the City and County of San Francisco must report to HUD on program outcomes, service utilization, and needs of program participants. We need to gather this information in order to monitor S+ C and to coordinate services to better meet the needs of program participants. In the long run, it is hoped that this information will enable us to continue to make CCCYO - TISH housing available, and to maintain and expand those services which you find helpful.

In order to do this, service providers need to share information with each other and with S+C service utilization. Whenever possible, this information will be shared on an anonymous basis, and your name will not be used. Case Management Staff will ask to speak with you on a regular basis to learn about your experience in the program, including service you have found useful.

Please read and complete the section below. If you have any question, please consult the housing sponsor or CCCYO - TISH representative who provide this form to you. Once you have read and understood the form, your signature will authorize information to be shared only as necessary.

Program participants complete this section:

I have read this form and understand that I will be asked to speak with Case Management Staff about the services I use and my experience in the program. I understand that CCCYO - TISH Program needs to contact agencies to monitor the Program. My signature below serves as a one (1) year release for:

1. The San Francisco Department of Human Services, Department of Public Health (DPH), DPH/Division of Mental Health and Substance Abuse Services, DPH/AIDS Office and Department of Veterans Affairs Medical Center to provide information to CCCYO - Treasure Island Supportive Housing Program about any records relating to me; and for
2. Community agencies providing services under contract to any of the entities named above to provide information to the Shelter + Care Program about any records relating to me.
3. To provide information to the Shelter + Care Program about any records relating to me.

This authorization is granted on the condition that due care be exercised at all times with respect to my rights to privacy and confidentiality. This authorization is not a waiver of any right or privilege conferred on me by law or regulation. Disclosure of the information herein is required for program monitoring. This form has been read by or to me prior to this signature. The consent is subject to revocation by the undersigned at anytime.

Signature
(Program participant)

Print Name
(Program participant)

Date: _____

Witnessed by:

Program Staff Signature

Print Name

Title

Date: _____

CONFLICT OF INTEREST DISCLOSURE STATEMENT

Name: _____

Address of Shelter + Care site where you may be housed (If known):

Organization in which I have a family or business tie:

I hereby certify that the information stated above is true and complete. I have no other ties or potential conflicts with the Shelter + Care Program. I will notify the Shelter + Care Program immediately of any potential conflict of interest or potential appearance of a conflict of interest if such arises in future.

Signature
(Program participant)

Date: _____

Print Name
(Program participant)

Secondary Resident Signature
(Program participant)

Date: _____

Print Name
(Program participant)



RELEASE OF REPRODUCTIVE LIKENESS

I hereby authorize the use of my photograph and likeness for any Catholic Charities CYO Treasure Island Supportive Housing promotional materials, publicity, or educational purposes.

I waive all claims for compensation for such use or the release of liability for any compensatory damages.

Signature
(Program participant)

Print Name
(Program participant)

Date: _____

Secondary Resident Signature
(Program participant)

Print Name
(Program participant)

Date: _____

Witnessed by:

Program Staff Signature

Print Name

Title

Date: _____

OBSERVATIONS, SUMMARY AND RECOMMENDATIONS

Observations:

**Summary of
interview/intake:**

**Recommendations of
client service needs and
goals:**
