**Intake Form Template**

Name of your organization here

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| **Individual Information:**  |
| Full Name:   | Date of Birth:   |
| Legal Name (If different than above):  | Check one:       □ Under 18     □ Over 18   |
| Gender Identity: | Sexuality | Pronouns:  |
| Phone Number:   | Email Address:  |
| Funding Source:   | Comments:  |

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| **If you are under 18, please have a parent or legal guardian fill out this section:**  |
| Parent/Legal Guardian Full Name:   |
| Home Phone:   | Cell phone:   |
| Email address:   |
| Address:   |
| I consent to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ moving into [Home Name]  and receiving services and programming as provided through [Organization].  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |
| **Participant Consent:**  |
|    I consent to moving into [Home Name] and receiving services and programming as provided through [Organization].  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**Additional Information**

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| School Name:   | School Phone Number:   |
| Grade/Expected Graduation:   | School Address:   |
| Do you volunteer/work with/access services at any other community organizations?   |
| Relationship Status:  □ Single     □ Partnered    □ Married   □ Divorced    □ Widowed  |
| **Release of Information:**  |
|       I give permission for [Home Name] Staff to collect monies and communicate directly with my [Social Services Payments] worker:  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |

**Release of Information**

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| **Health Providers:**  |
| Physician Name:   | Phone Number:   |
| Clinic Name:   | Address:  |
| Pharmacy:   | Phone Number:   |
| Dentist Name:   | Phone Number:   |
| Office Name:   | Address:   |
| Psychiatrist Name:   | Phone Number:   |
| Office Name:   | Address:  |
| Counsellor Name:   | Phone Number:   |
| Office Name:   | Address:   |
| **Other:**  |
| Name:    | Phone Number:   |
| Service:   | Address:   |
| Name:    | Phone Number:   |
| Service:   | Address:   |

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|  I give permission for [Home Name] staff to communicate directly with these service providers, with the exception(s) of:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for the purpose of assisting my ongoing care and case management. I understand that I can revoke or change this consent at any time by notifying [Home Name] staff.   Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |

**Intake Questions**

*Past housing experience*

What is your current housing situation?

Describe what you currently know about [Home Name].

Describe any other group homes you’ve lived in (if applicable).

*Getting to know you*

What is your greatest strength?

What is your biggest accomplishment?

What do you like to do to bring yourself joy? (e.g., programming, self-care plans)

What is your love language? (i.e., what makes you feel seen or heard)

*Taking care of yourself*

What are ways that you deal with or navigate big emotions or obstacles in your life? (e.g., triggers, setbacks, addictions, abuses, etc.)

Describe what your support team looks like? (e.g., groups, friends, family, etc.)

Describe any physical or mental health struggles you have to manage on a weekly basis?

Describe your current substance usage (e.g., tobacco, alcohol, cannabis)

Describe your current knowledge and ability of navigating systems? (e.g., education, health care funding, independence etc.)

*Looking forward*

What kind of life do you envision for yourself at [Home Name]?

What are your biggest dreams for your future?

**[Home Name] Program Agreement**

This agreement is between [Organization] & [Home Name] and the program participant.

This agreement commences on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This agreement ends on the date which:

* [Organization] & [Home Name] terminates the agreement in writing.
* The program participant terminates the agreement in writing.

By signing this agreement, you (the participant) agree that you will participate in [Home Name] by:

* Contributing towards your housing costs as agreed upon at the time of lease signing
* Meeting with staff regularly to conduct case plans and work towards self-identified goals
* Following the Basic Expectation of [Home Name] residents
* Following the House Rules of [Home Name]

By signing this agreement, you understand that:

* The goal of [Home Name] staff is to connect you to services in the community of your choice so that you are properly supported and able to sustain your achievements and housing
* If [Home Name] staff is concerned about your safety/well-being, we may contact your landlord, enter your room, and contact your health care team, mental health team, emergency responders, and any other service providers to ensure your safety.

By signing this agreement, we ([Organization] & [Home Name]) agree to:

* Treat you with dignity and respect
* Work alongside you to determine appropriate care to meet your individual needs
* Support you to achieve your self-identified goals by linking you to appropriate services

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to the terms set for this agreement.

(print name)

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

Staff Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Consent for Services**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ consent to the provision of the programs and services delivered by the staff at [Home Name], a division of [Organization]. I confirm that I have been informed about the proposed services and programming and offered the opportunity to ask questions. I understand that the program generally consists of:

* residence at [Home Name]
* life skills and mentoring
* educational and employment support
* case planning and goal setting
* staff support and advocacy
* holistic health services

I specifically give consent for the following and understand I can revoke my consent at anytime by notifying [Home Name] staff:

* Transportation in the community through the use of the [Home Name] vehicle
* Administration of any prescription or over-the-counter medication prescribed or authorized by a physician
* Emergency medical treatment by a medical practitioner, nurse practitioner, or paramedic in case of accident or illness; any emergency medical, surgical, anesthetic, and/or dental treatment with a licensed practitioner as needed; and admission to a local hospital if deemed necessary.

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

Staff Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Confidentiality Agreement**

I understand that my personal information is used to provide services to me, and that information about me is confidential and will not be released for other purposes without my consent. I understand that all information about me and my affairs is subject to federal and provincial privacy laws, specifically the *Freedom of Information and Protection of Privacy Act.* I understand that my file may be reviewed for the Program Quality Review process and accreditation. I understand that I can request an appointment to see my file at any time.

By signing, I agree that [Home Name], a division of [Organization], may release case management and case planning information to other service providers invested in my case management.

I understand that I can revoke this consent at any time by notifying [Home Name] staff.

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

Staff Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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| ***Note: Please take this open access template and adjust it to your organization’s needs and specifications.*** |