## **GENERAL INTAKE FORM**

## Red River Valley Community Action, 4212 Gateway Dr, Grand Forks ND 58203 Phone: 701-746-5431; Fax: 701-746-0406

Office Use Only				
Project Start Date/	Staff			
Name of Head of Household				
Family Type: Single Person Fa	amily Other			
Client Record				
Name First Middl		Suffix		
Social Security Number				
U.S. Veteran No Yes	5			
Mailing Address Street	City			
State Zip Code				
Primary Phone Secondary Phone				
Email Address				
CLIENT DEMOGRAPHICS				
Date of Birth/				
Gender (s) Woman (girl, if child)	Man (boy, if child)Transgende	r		
Non-Binary Quest	tioning Culturally Specific Identity (e.g. Two-Spirit)	,		
Different Identity (specify):				
Client prefers not to answer	r			

Race (s) America	an Indian, Alaska Native, or Indiger	nous Asian or Asian American			
Black, African American, or African Hispanic/Latino/e/o					
Middle Eastern or North African Native Hawaiian or Pacific Islander					
White	Client prefers not to answ	er			
Additional Race & Ethnici	ty:				
(optional)	specif				
Relationship to Head of H	lousehold				
Self Head	of household's spouse or partner	Head of household's child			
Other relation to he	ead of household Non-rel	ation to head of household			
DISABILITIES					
	No Yes Client	prefers not to answer			
		prefere floor to dissile			
Disability Type	<b>Disability Determination</b>	If yes, expected to be of long- continued and indefinite			
DK = Client Doesn't Know duration and substantially					
PNTA = Client prefers not	to answer	impairs ability to live independently			
Alcohol Use Disorder	YesNoDKPNT	AYesNoDKPNTA			
Both Alcohol and Drug Use Disorders	YesNoDKPNT	AYesNoDKPNTA			
Chronic Health	Yes No DK PNT	A Yes No DK PNTA			
Condition		<del>_</del>			
Developmental Disability	YesNoDKPNT	AYesNoDKPNTA			
Drug Use Disorder	YesNoDKPNT	Yes NoDKPNTA			
HIV/AIDS	YesNoDKPNT	AYesNoDKPNTA			
Mental Health	V 11 21 -11-				
Disorder					
	YeSNODRPNTA	AYesNoDKPNTA			

HEALTH INSURANCE Covered by Health Insurance	No YesPNTA
Medicaid	NoYes
Medicare	No Yes
State Children's Health Insurance Pro	gram No Yes
Veteran's Health Administration	No Yes
Employer Provided Insurance	No Yes
Health Insurance through COBRA	No Yes
Private Pay Insurance	No Yes
State Health Insurance for Adults	No Yes
Indian Health Services Program	No Yes
Other (specify)	No Yes
MONTHLY INCOME  Income from any source	No Yes DK PNTA
Alimony or other spousal support	No Yes \$
Child Support	No Yes \$
Earned income (employment)	No Yes \$
General Assistance (GA)	No Yes \$
Other (specify)	No Yes \$
Pension or retirement income from a former job	No Yes \$
Private disability insurance	No Yes \$
Retirement income from Social Security	No Yes \$
Social Security Disability Insurance (SSDI)	No Yes \$
Supplemental Security Income (SSI)	No Yes \$

Monthly Income (continued)				
Temporary Assistance for Needy No Yes \$ Families (TANF)				
Unemployment Insurance No Yes \$				
VA Non-Service-Connected No Yes \$ Disability Pension				
VA Service-Connected Disability No Yes \$ Pension				
Worker's Compensation No Yes \$				
Total Monthly Income \$				
NON-CASH BENEFITS  Non-cash benefits from any source  No Yes Client prefers not to answer				
Supplemental Nutrition Assistance (SNAP) No Yes (previously known as food stamps)				
Special Supplemental Nutrition Program No Yes for Women, Infants & Children (WIC)				
TANF child care services No Yes				
TANF transportation services No Yes				
Other TANF-funded services No Yes				
Other (specify) No Yes				
Employed No Yes				
If Yes, type of employment Full-time Part-Time Seasonal/Sporadic (including day labor)				
If No, why not employed Looking for work Unable to work Not looking for work				
DOMESTIC VIOLENCE				
Survivor of domestic violence? No Yes Client prefers not to answer				
If yes, when experience occurred Within the past 3 months 3 to 6 months ago				
6 to 12 months ago More than a year ago DKPNTA				
If yes, currently fleeing? No Yes DK PNTA				



Signature of Staff

(Name)	(Social Security Number)	(Date of Birth)
give permission to the agency staff and other agen concerning myself and/or dependents. My name a discussion of my needs with other service agencies	s well as other identifying information	
TI G G P N L G N G C S G S G S O O O O	rand Forks County Social Services he Salvation Army rand Forks Housing Authority rairie Harvest orth Dakota Job Service ocal Law Enforcement & Probation ortheast Human Service rand Forks Public Health egal Services of North Dakota rea Churches:ommunity Violence Intervention Center Joseph's Social Care rand Forks Public Schools ocial Security (SSI & SSDI) alley Health fomen, Infant, Children (WIC) ivision of Community Services/Departither – Please specify:ther – Please specify:there – Please specify:there – Please specify:there – Please specify:there = Please specify:there = Please specify:there = Please specify:there = Please specify:	ment of Commerce (DCS/DOC)
understand that this information will be shared onlassist me in obtaining services. I understand that n		
understand that I have the right to not supply the not be able to provide me with the services that I a		ut this information, the agency may
understand that I may cancel this document at an written statement asking that these privileges be te closure.		
Please add me to the RRVCA email list so	I can stay informed about new progran	ns, services and special events.
Email Address:		
Signature of Client	Date	

A PHOTOCOPY OF THIS CONSENT WILL BE CONSIDERED AS VALID AS THE ORIGINAL

Date