Tracy Community Connections Center
INTAKE FORM

Legal Name (Head of Household) M/F: ______________________________
Last First MIddle

Spouse - if applicable M/F: ____________ ____________ ____________
First and Last Name Date of Birth Social Security

Names of other people living in household

First and Last Name	Date of Birth	Social Security	Relationship	Age

Current Address: ______________________ ______________________
Number Street Apt# City State Zip Code

E-mail Address: ______________________

Home Telephone No: ____________ **Work/Cell Telephone No**: ____________

Ethnicity: ________ **Gender**:________ **SSN#**: ________ **DOB**: ________

Marital Status: ⬜ Single ⬜ Married ⬜ Seperated ⬜ Divorced ⬜ Widowed ⬜ Other

Number of Children/Dependents living with you: ⬜**None** ⬜**1** ⬜**2** ⬜**3** ⬜**4** ⬜**5** ⬜**6** ⬜**7+**

Are you: ⬜ **Pregnant?** ⬜ **Disabled?** ⬜ **Frail?**
Please explain nature of checked conditions

____

Veteran Status: ⬜ Never in Service ⬜ Currently Serving ⬜ Veteran

Senior Citizen: ⬜ Yes ⬜ No ⬜ Decline to answer

Medical Insurance: ⬜ Yes ⬜ No ⬜ Health Net ⬜ Health Plan of San Joaquin

Other: ______________________________

Race And Ethnicity - Select all that apply

Racial Categories	American Indian or Alaska Native	Asian	Black or African American	White	Hispanic	Other	Total %
Person 1							
Person 2							
Children							

Income - Circle the total number of family members and income

2023	Total Family Members	1	2	3	4	5	6	7	8
San Joaquin County Area Median Income: $100,300	Acutely Low	10550	12050	13550	15050	16250	17450	18650	19850
	Extremely Low	18450	21050	24860	30000	35140	40280	45420	50560
	Very Low Income	30700	35100	39500	43850	47400	50900	54400	57900
	Low Income	49100	56100	63100	70100	75750	81350	86950	92550
	Median Income	70200	80250	90250	**100300**	108300	116350	124350	132400
	Moderate Income	84250	96300	108300	120350	130000	139600	149250	158850

Employment Status

Are you employed? ☐ **Yes** ☐ **No** ☐ **Full Time** ☐ **Part Time**

Are you physically/emotionally able to work? ☐ **Yes** ☐ **No**

Income

Income received by **ALL** family members: (All sources of income includes earnings from full-time, part-time, seasonal jobs, welfare payments, General Relief, SSI/SSA, pensions, child support, alimony, unemployment, foster care payments, adoption payments, any income received on behalf of children, etc.)

Type of Income	Name of Person Receiving Income	Name of Agency/Company	Contact Number of Company/Agency	Gross Monthly Income
☐Part ☐Full				$______
☐Part ☐Full				$______
☐Part ☐Full				$______

Public Assistance

FOOD STAMPS ______________________ ☐ Verification $__________

TANF ______________________ ☐ Verification $__________

SOC SECURITY ______________________ ☐ Verification $__________

GR ______________________ ☐ Verification $__________

DISAB/WORK COMP ______________________ ☐ Verification $__________

CHILD SUPPORT ______________________ ☐ Verification $__________

UNEMPLOYMENT ______________________ ☐ Verification $__________

HOUSEHOLD MONTHLY INCOME (WAGES AND PUBLIC ASSISTANCE) TOTAL: $__________

Utilities

Does your household have these basic utilities: ☐ **phone** ☐ **gas** ☐ **water** ☐ **electricity**

VERIFICATION OF INCOME

Applicant Name: ______________________

Instructions for Employer/Payment Source Representative: This is to certify the income received by the above named individual for purposes of participating in the program. This information will be used only to determine the eligibility status and level of benefit of the household. **Complete only the selected section below that indicates an authorization to release information.**

Please return this form to:

Name & Title: Case Manager — Phone: (209) 407-9649

Address: 95 W 11th Street, Suite 206 Tracy, CA 95376 — Fax: (209) 940-0028

E-mail: casemanagers@tracyccc.org

☐ Employment Income ☐ I am not currently employed

Applicant Release: I hereby authorize the release of the following employment information.

Applicant Signature: ______________________ Date: __________

Employer representative to complete this section:

The person named above is employed by ______________________ since ______________.

He/She is paid $____________ on a ____________ basis and is currently working an average of

__________ hours per ____________.

Additional compensation please specify (if any): ______________________

Probability of continued employment: ______________________

Authorized Employer Representative Signature: ______________________ Date __________

Name & Title: ______________________

Address & Phone: ______________________

☐ **Payments and/or Benefit Income (complete one form for each distinct source of income for person named above)**

CIRCLE ONE:

Social Security/SSI	**Pension/Retirement**	**TANF**
Public Assistance	**Unemployment**	**Workers Compensation**
Alimony Payments	**Compensation Foster Care**	**Child Support Payments**
Armed Forces Income	**Payments (AB12)**	

Other (Please specify): ______________________

Applicant Release: I hereby authorize the release of the following employment information.

Applicant Signature: ______________________ Date: __________

Payment source representative to complete this section:

Payments or benefits in the amount of $ ______________ are paid on a ____________ basis. The expected duration of the payments or benefits is ______________________.

Authorized Payment Source Representative Signature: ______________________ Date: __________

Name & Title: ______________________

Address & Phone: ______________________

Name of Adult Participant and/or Parent of Legal Guardian of Minor

____ ______________________

First and Last Name (printed) Birth Date

Release of Information

I, ______________________ hereby give permission to the Tracy Community Connections Center (TCCC) to share any of the above information with their partnering agencies in order that the County might handle my case in the most efficient manner possible. The TCCC will not share the above information with any persons or agency which are not part of the County unless it is mandated to do so by law. In addition, I am willing to be contacted at home by staff from the TCCC for the purposes of case management and program evaluation.

Signature: ____ **Date:** ______________

In signing this form I also understand and consent to the following:

1. Rental Assistance is not guaranteed even when a person appears to be eligible during the first client screening.
2. All information will need to be verified with appropriate documentation before any rental assistance is given.
3. Client confirms, under penalty of perjury, that all information is accurate and true to the best of their knowledge.

I AGREE TO OBSERVE AND OBEY ALL POSTED RULES AND WARNINGS AND FURTHER AGREE TO FOLLOW ANY ORAL INSTRUCTIONS AND DIRECTIONS GIVEN BY ANY AND ALL REPRESENTATIVES OF TRACY COMMUNITY CONNECTIONS CENTER INC., INCLUDING VOLUNTEERS.

____ ______________________

Signature of Adult Participant and/or Parent/Guardian if a minor participant **Date**

____ ______________________

Case Manager **Date**

Tracy Community Connections Center

Clarity #: ______________

AUTHORIZATION FOR EXCHANGE AND RELEASE OF INFORMATION

We may have many services here at the Tracy Community Connections Center to help you and our family. To receive help and to make sure that you get all the help you and your family need, we will need to exchange information with other agencies so that we can better serve you. I, ______________________________, hereby authorize release of all records, documents and information on my son, my daughter
Parent/Legal Guardian
and/or my family listed on this page, which is or may come on file with agencies that are part of the integrated service teams of the Tracy Community Connections Center.

Participant's First Name	**Participant's Last Name**	**Date of Birth**	
Partner's First Name	**Partner's Last Name**	**Date of Birth**	
First Name	**Last Name**	**Date of Birth**	**Relationship**
First Name	**Last Name**	**Date of Birth**	**Relationship**
First Name	**Last Name**	**Date of Birth**	**Relationship**
First Name	**Last Name**	**Date of Birth**	**Relationship**

☐ SEE ATTACHED SHEET FOR ADDITIONAL FAMILY MEMBERS

We, CPF, will exchange information with the following agency OR individual/s.

- Housing Authority
- SJ Juvenile Probation Department
- San Joaquin County Work Net
- Clear Point
- SJC Children's Services
- SJC Behavioral Health
- Women's Center Youth & Family Services
- City of Stockton
- Police Department
- SJC Public Health
- Planned Parenthood
- SJC Human Services Agency
- Family Resource and Referral/CPFSJ
- SJ Delta College
- First 5 of San Joaquin
- California Rural Legal Services
- SJC Office of Ed.
- Building Blocks
- Adopt a Child
- Boys and Girls Club
- Salvation Army
- El Concilio
- Catholic Charities
- EDD
- CA Human Development Corp.
- Child Abuse Prevention Council
- Food Bank
- Crossroads
- Head Start
- Good Will
- Health Plan of San Joaquin
- APSARA
- VIVO
- Community Medical Center
- Delta Health Care
- SJC District Attorney
- IRS
- Homeless Shelter ______________
- Law Enforcement ______________
- School District ______________
- Other______________
- Other______________

I understand that the following information may be released to the above stated providers:

1. The full name and other identifying information regarding me, my children and my family.
2. Recommendations to other providers for further assistance.
3. Diagnostic and assessment information including psychological and psychiatric evaluations, medical histories, educational and social histories for the purpose of helping my family through the integrated service team process.

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law and therefore prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

I understand that I may remove any of the above agencies or individuals by crossing their name out and adding my initial. Any changes requested after today's date ________ must be made in writing. Unless requested in writing, this release will remain in effect for 12 months from the date signed.

I authorize that this form was completed in its entirety and was read by me or read to me prior to signing.

Signature	**Relationship**	**Date**
Signature	**Relationship**	**Date**
Tracy CCC Staff/Volunteer Signature	**Date**	

Consent for Release of Information

To:____(Agency Name)

Name of individual: ____

I authorize the above-named agency to collect information or records, including but not limited to protected personal information, about me through the Homeless Management Information System of the San Joaquin Continuum of Care.

Data collected can be used according to the SJCoC HMIS Policies and Procedures and the SJCoC HMIS Privacy Policy and Data Sharing Policy. By signing this Release of Information, I certify that I understand my rights in relation to the collection, protection, and sharing of data through the HMIS.

By signing, I acknowledge that I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian and legally authorized to obtain these records. I acknowledge that any knowingly false representation made to obtain information from the above-named agency can lead to punishment by fine, imprisonment or both.

Client/legal guardian signature:____________________________________ Date: ___________

Intake for Clients

San Joaquin Continuum of Care

Client Profile questions

Client name: ____ **Date of contact:** ________________________

Social Security Number: _____________________________________ **Date of Birth:** __________________________

Gender: ☐ Woman/Girl ☐ Man/Boy ☐ Culturally Specific Identity ☐ Transgender

☐ Non-binary ☐ Questioning ☐ Different Identity ☐ Client doesn't know

☐ Client prefers not to answer ☐ Data Not Collected

Race and Ethnicity (check all that apply):

☐ American Indian/Native Alaskan/Indigenous ☐ Asian/Asian American ☐ Black/African American/African
☐ Hispanic/Latino/a/x ☐ Middle Eastern/North African ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Client prefers not to answer ☐ Client prefers not to answer
☐ Data not collected

Is there an adult in the household with a permanent disability?: ☐ Yes ☐ No

Are you fleeing domestic violence or an abusive situation?: ☐ Yes ☐ No

Are you a Military Veteran?: ☐ Yes ☐ No **ZIP of last current address:**__________________________

Contact questions

Phone #: ______________________ **Email:** ____

Current address (if applicable):____

Program Enrollment questions

Current living situation (where was household last night?):

☐ Emergency shelter
☐ Transitional housing for homeless
☐ Permanent housing for formerly homeless
☐ Psychological hospital/facility
☐ Substance abuse treatment facility
☐ Detox center
☐ Hospital/jail/prison/juvenile detention facility
☐ Staying with family members
☐ Staying with friends
☐ Foster care or foster group home
☐ Place not meant for human habitation
☐ Hotel/motel paid by HSA or charity
☐ Hotel/motel paid by household
☐ Rental by client with ongoing VASH subsidy
☐ Rental by client with other ongoing subsidy
(Type of subsidy:_______________________________)
☐ Owned by client with ongoing subsidy
☐ Rental by client with no ongoing subsidy
☐ Owned by client with no ongoing subsidy
☐ Other (_______________________________________)
☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Length of Stay in that situation?: ☐ 1 night or less ☐ 2 – 6 nights ☐ 1 week to 1 month ☐ 1 month to 90 days

☐ 90 days to 1 year ☐ 1 year or longer ☐ Client doesn't know ☐ Client refused ☐ Data not collected

Approximate Date homelessness started: __________

Number of times on the streets or in emergency shelter in the past 3 years: __________

Total number of months homeless on the streets or in emergency shelter in the past 3 years: __________

Do you have a disabling condition: ☐ Yes ☐ No

Physical Disability: ☐ Yes ☐ No **Is it of long-term duration:** ☐ Yes ☐ No

Developmental Disability: ☐ Yes ☐ No **Is it of long-term duration:** ☐ Yes ☐ No

Chronic Health Condition: ☐ Yes ☐ No **Is it of long-term duration:** ☐ Yes ☐ No

HIV-AIDS: ☐ Yes ☐ No **Is it of long-term duration:** ☐ Yes ☐ No

Mental Health Disorder: ☐ Yes ☐ No **Is it of long-term duration:** ☐ Yes ☐ No

Substance Use Disorder: ☐ Yes ☐ No **Is it of long-term duration:** ☐ Yes ☐ No

Check if: ☐ Alcohol use disorder ☐ Substance use disorder ☐ Alcohol and Substance use disorder (both)

Domestic Violence survivor: ☐ Yes ☐ No **Last occurrence you experienced was (date):** _____________

Are you currently fleeing Domestic Violence, abuse, or stalking: ☐ Yes ☐ No

Do you have income from any of the following sources (and the monthly amount)? ☐ Yes ☐ No

☐ Earned Income ____________
☐ SSI ____________
☐ VA Service disability ____________
☐ Private disability ____________
☐ TANF (aka cash aid) ____________
☐ Social Security retirement ____________
☐ Child Support ____________
☐ Other Income Source ____________
☐ Unemployment insurance ____________
☐ SSDI ____________
☐ VA Non-service disability ____________
☐ Worker's Compensation ____________
☐ General Assistance ____________
☐ Pension or job retirement ____________
☐ Alimony or similar ____________

Total Monthly Cash Income: ____________

Do you receive any of the following benefits? ☐ Yes ☐ No

☐ SNAP (aka food stamps)
☐ WIC
☐ TANF Childcare services
☐ TANF transportation services
☐ Other TANF services
☐ Housing Choice Voucher (aka Section 8)
☐ Other non-cash benefit

Do you have Health Insurance? ☐ Yes ☐ No

☐ MEDICAID

☐ Health Plan of San Joaquin #___________________ ☐ Health Net #___________________

☐ MEDICARE

☐ VA Medical Services

☐ COBRA

☐ State Health Insurance for Adults

☐ Other health insurance program

☐ State Children's Health Insurance Program

☐ Employer-provided health insurance

☐ Private pay health insurance

☐ Indian Health Services Program

Other household questions

The Number of people in household who are: ____ Adults 18 & over _____ Children under 18

If in housing, current monthly rent: ___________

If in housing, household has a Notice to Pay or Quit: ☐ Yes ☐ No

Intake/Enrollment was completed by: ____

Agency the above individual works for: ____

Phone number: ____________________ Email: ____

TRACY COMMUNITY CONNECTIONS CENTER

RESOURCES FOR HOMELESS & AT-RISK

Affordability Worksheet

Section I:

Participant Name: ____

Date: ______/______/___________

Phone Number: (___)____-__________

Section II:

Household Income **Include income for all HH members.**	
CalWORKs Cash Assistance/TANF	$
Income From Employment	$
Social Security (Disability,Retirement,SSI)	$
Unemployment Insurance	$
Child Support	$
Other:	$
Total:	**$**

Housing Expenses **Housing related expenses only.**	**Monthly Amount**
Rent	$
Renter's Insurance	$
Mortgage	$
Property Taxes	$
Homeowner's Insurance	$
Homeowner's Association (HOA) Fees	$
Utilities	$
Other	$
Total:	**$**

Percentage of Income being paid for Housing Expenses	
Housing Expense Total	$
(divided by)	÷
Monthly Gross Income (before taxes)	$
(move the decimal 2 places right)	=
Percentage Monthly Housing Cost	**%**

Section III:

Other Expenses	
Groceries	$
Personal Care Items	$
Toilet Paper	$
Cleaning Supplies	$
Laundry Supplies	$
Car Payment	$
Car Insurance	$
Gas	$
Bus Fares	$
Other Transportation	$
Medical Co-pays	$
Prescriptions	$
Non-Prescription Medication	$
Other Medical Expenses	$
Student Loan Payment	$
Bank Loan Payment	$
Credit Card Payment	$
Court Fees	$
Collections	$
Pets	$
Entertainment	$
Other:	$
Other:	$
Other:	$
Total:	**$**

Percentage of Income being paid for Other Expenses	
Other Expense Total	$
(divided by)	÷
Monthly Gross Income (before taxes)	$
(move the decimal 2 places right)	=
Monthly Debt-to-Income Ratio	**%**

Section IV:

Target Household Expense Percentage	
Monthly Gross Income (before taxes)	$
(multiply by)	X
Ideal Percentage is no more than 80% of Gross Income	0.80
Target Total Monthly Expense Amount	**$**

TRACY COMMUNITY CONNECTIONS CENTER
RESOURCES FOR HOMELESS & AT-RISK

Community Support (CS) Services
Referral Form

Select One		Community Support Service Short Description & Criteria — Section E
☐	Housing Transition Navigation Services **(HTNS)**[1]	*Services to help eligible members obtain housing.* **MUST MEET ONE OF THE FOLLOWING:** ☐ Member is prioritized for a permanent supporting housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system ☐ Member meets the Housing and Urban Development (HUD) definition of homeless ☐ Member meets the Housing and Urban Development definition of at risk of homelessness ☐ Member is a child or youth who does not meet the HUD definition of "homeless" but qualifies as "homeless" under other federal or state laws[4] **AND** ☐ Member has at least one **qualifying circumstance**[2]
☐	Housing Deposits **(HD)**[1] Once-in-a-lifetime service	*Services to help fund one-time fees and/or deposits, including modifications necessary for eligible members to establish a basic household.* ☐ Member is receiving Housing Transition Navigation Services (HTNS)
☐	Housing Tenancy and Sustaining Services **(HTSS)**[1] Once-in-a-lifetime service	*Services to help eligible members maintain safe and stable tenancy once housing is secured.* **MUST MEET ONE OF THE FOLLOWING:** ☐ Member is receiving Housing Transition Navigation Services (HTNS) ☐ Member is prioritized for a permanent supporting housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system ☐ Member meets the Housing and Urban Development (HUD) definition of homeless ☐ Member meets the Housing and Urban Development definition of at risk of homelessness ☐ Member is a child or youth who does not meet the HUD definition of "homeless" but qualifies as "homeless" under other federal or state laws[4] **AND** ☐ Member has at least one **qualifying circumstance**[2]

[1] Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

[2] **Qualifying circumstances** include **a**) Receiving Enhanced Care Management (ECM) services, or **b**) Have at least one serious chronic condition or serious mental illness, or **c**) At risk of institutionalization or overdose or requiring residential services as a result of a substance use disorder, or **d**) Have a serious emotional disturbance (children & adolescents only), or **e**) A transition-age youth with conviction(s), or history of foster care, or involvement with juvenile justice or criminal justice, or victims of trafficking or domestic violence.

[3] **Qualifying chronic conditions** include, but are not limited to, **a**) Diabetes, **b**) Cardiovascular Disorder, **c**) Congestive Heart Failure, **d**) Stroke, **e**) Chronic Lung Disorder, **f**) Human Immunodeficiency Virus (HIV), **g**) Cancer, **h**) Gestational Diabetes, **i**) High-Risk Perinatal Condition, **j**) Chronic or Disabling Mental/Behavioral Health Disorders. The diagnosis must be verifiable through the member's medical records.

Please circle your qualifying circumstance above or write it here ____

I, _________________________________ request to receive the above Community Support Services through the Tracy Community Connections Center. I agree to complete a housing assessment and housing plan with my case manager.

Client Signature: ____ Date: ____________________

Case Manager Signature: ____ Date:_____________________

HOMELESS CERTIFICATION

Client Name: ____

☐ Household without dependent children (complete one form for each adult in the household)
☐ Household with dependent children (complete one form for household)
Number of persons in the household: _________

This is to certify that the above named individual or household is currently homeless based on the check mark, other indicated information, and signature indicating their current living situation.

Check only one box and complete only that section

Living Situation: place not meant for human habitation (e.g., cars, parks, abandoned buildings, streets/sidewalks)

☐ The person(s) named above is/are currently living in (or, if currently in hospital or other institution, was living in immediately prior to hospital/institution admission) a public or private place not designed for, or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus station, airport, or camp ground.

Description of current living situation: ____

____

Homeless Street Outreach Program Name:_____Tracy Community Connections Center_____

This certifying agency must be recognized by the local Continuum of Care (CoC) as an agency that has a program designed to serve persons living on the street or other places not meant for human habitation. Examples may be street outreach workers, day shelters, soup kitchens, Health Care for the Homeless sites, etc.

Authorized Agency Representative Signature: ___________________________ Date: _______________

Living Situation: Emergency Shelter

☐ The person(s) named above is/are currently living in (or, if currently in hospital or other institution, was living in immediately prior to hospital/institution admission) a supervised publicly or privately operated shelter as follows:

Emergency Shelter Program Name: ____

This emergency shelter must appear on the CoC's Housing Inventory Chart submitted as part of the most recent CoC Homeless Assistance application to HUD or otherwise be recognized by the CoC as part of the CoC inventory (e.g. newly established Emergency Shelter).

Authorized Agency Representative Signature: ___________________________ Date: _______________

Living Situation: Transitional Housing

☐ The person(s) named above is/are currently living in a transitional housing program for persons who are homeless. The persons(s) named above is/are graduating from or timing out of the transitional housing program:

Transitional Housing Program Name: ____

This transitional housing program must appear on the CoC's Housing Inventory Chart submitted as part of the most recent CoC Homeless Assistance application to HUD or otherwise be recognized by the CoC as part of the CoC inventory (e.g. newly established Transitional Housing program).

Immediately prior to entering transitional housing the person(s) named above was/were residing in:

☐ emergency shelter OR ☐ a place unfit for human habitation

Authorized Agency Representative Signature: ___________________________ Date: _______________

I declare under the penalty of perjury that the above information is true and correct.

Client Signature:___________________________________ **Date:** ____________________

TRACY COMMUNITY CONNECTIONS CENTER
HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I,____, give my permission for **Tracy Community Connections Center** to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Health Information

I would like to give the above Community Based organization permission to:

Check the box that describes how you want your information to be disclosed

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results,treatment, and billing records for all conditions.

Or

☐ Disclose my complete health record except for the following information

- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Alcohol/drug abuse treatment records
- ☐ Genetic information
- ☐ Other (Specify)

____

____

____

____

Form of Disclosure:

- ☐ Electronic copy or access via a web-based portal
- ☐ Hard copy

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write ‘at my request’.

____

____

____

____

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following organization

Organization: Tracy Community Connections Center
Address: 95 W 11th Street, Suite 206, Tracy, CA 95376

I understand that the organization listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:
Tick as appropriate

a) From ____________________ to ____________________

Or

b) All past, present, and future periods

Or

c) The date of the signature in section VI until the following event:____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: Compliance Officer
Organization: Tracy Community Connections Center
Address: 95 W 11th Street, Suite 206, Tracy, CA 95376

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

Signature: ____________________________________ Date: ____________________________

Print your name: ____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: ____

Signature of person completing this form: ____

Describe below how this person has legal authority to sign this form:

____

COMMUNITY SUPPORT SERVICES ASSESSMENT

Name: ______________________________________ **Date:** ________________________

Insurance ☐ Health Plan of San Joaquin ☐ Health Net **Client Date of Birth:** _ _ / _ _ / _ _ _ _
(Month) (Day) (Year)

Case Manager: _____________________________ **Staff** ____________________________________

Housing Barriers

Barriers to Housing - *Please mark all that apply*

☐ No rental history
☐ Eviction(s) ______
☐ Large family (3+ children)
☐ Single parent household
☐ Head of household under 18
☐ Sporadic employment history
☐ No high school diploma/GED
☐ Insufficient income or no income
☐ Insufficient savings
☐ Other ________________________

☐ Debts
☐ Repeated or chronic homelessness
☐ Recent history of substance abuse or actively using drugs or alcohol
☐ Recent or past criminal history
☐ Adult or child with mild to severe behavioral problems
☐ History of abuse and/or battery but abuser not in the unit
☐ Recent or current abuse and/or battering (client fleeing abuser)
☐ No credit history or poor credit history
☐ Disabled ☐ Mental ☐ Physical _______________________
☐ Other ____

Identification/Paperwork

Which Documents do you have and which ones can we help you to get :

Document				
Social Security Card	☐ No	☐ Yes	☐ Needs to Obtain	☐ Applied for ___________
Birth certificate	☐ No	☐ Yes	☐ Needs to Obtain	☐ Applied for ___________
State ID	☐ No	☐ Yes	☐ Needs to Obtain	☐ Applied for ___________
Green Card/Work Permit	☐ No	☐ Yes	☐ Needs to Obtain	☐ Applied for ___________
Passport to Services	☐ No	☐ Yes	☐ Needs to Obtain	☐ Applied for ___________
SSI/SSDI Award Letter	☐ No	☐ Yes	☐ Needs to Obtain	☐ Applied for ___________
Medi-Cal/Insurance Card	☐ No	☐ Yes	☐ Needs to Obtain	☐ Applied for ___________
EBT Card	☐ No	☐ Yes	☐ Needs to Obtain	☐ Applied for ___________
211/ Coordinated Entry	☐ No	☐ Yes	☐ Called	☐ Apt Date ___________

Finances

Do you have a bank account? ☐ No ☐ Yes
☐ Checking $ ______ ☐ Savings $ ________
Chime Account ☐ No ☐ Yes
Varo Account ☐ No ☐ Yes
Go2Bank Account ☐ No ☐ Yes
Other type of account ☐ No ☐ Yes
Can you get a bank account ☐ No ☐ Yes
Are you in Chexx Systems ☐ No ☐ Yes
Do you have any assets ☐ No ☐ Yes
Details:____________________________
401k ☐ No ☐ Yes Stocks ☐ No ☐ Yes
Pension ☐ No ☐ Yes

Debt

Origin of Debt	Yes	No	Amount	Contact Info
Landlord			$	
Gas Company			$	
Electric			$	
Telephone			$	
Child Support			$	
IRS			$	
Car (Loan/Tickets)			$	
Student Loans			$	
Credit Cards			$	
Storage			$	
Other			$	
Total			$	

Transportation:

Do you have a vehicle ☐ No ☐ Yes
Do you have a bike ☐ No ☐ Yes
Do you have bus passes ☐ No ☐ Yes
Can you get a ride ☐ No ☐ Yes

Are you currently looking for work ☐ No ☐ Yes What was the last date you worked ______________________

Employment

Are you currently unable to work ☐ No ☐ Yes — What type of work was it ____________________
Are you currently employed ☐ No ☐ Yes — Name of Last Employer ____________________
How many hours did you work last week _______ — Contact Info ____________________
What type of work was it? ☐ Permanent ☐ Part Time ☐ Temporary ☐ Seasonal ☐ Cash ☐ Recycling

Have you signed up with any of the below temp agencies? Are you still eligible for assignments?

Labor Maxx	☐ No	☐ Yes	Express Employment	☐ No	☐ Yes	First Staffing	☐ No	☐ Yes
Hedy Holmes	☐ No	☐ Yes	Snelling Staffing	☐ No	☐ Yes	Other ________		
Adecco	☐ No	☐ Yes	Golden State	☐ No	☐ Yes	Other ________		
Sun Express	☐ No	☐ Yes	Bayside Solutions	☐ No	☐ Yes	Other ________		
WorkNet	☐ No	☐ Yes	Other ____________________					

Community Connections

Are you signed up with any of the below community service providers or agencies?

CMC	☐ No	☐ Yes	Tracy Interfaith	☐ No	☐ Yes	Family Resource & Referral	☐ No	☐ Yes
St Bernards	☐ No	☐ Yes	Chest of Hope	☐ No	☐ Yes	Valley Community Counseling	☐ No	☐ Yes
PATH	☐ No	☐ Yes	Sow a Seed	☐ No	☐ Yes	Behavioral Health	☐ No	☐ Yes
Senior Center	☐ No	☐ Yes	Familiar Faces	☐ No	☐ Yes	Salvation Army	☐ No	☐ Yes
Mobile Showers	☐ No	☐ Yes	Community Meals	☐ No	☐ Yes	Local Church	☐ No	☐ Yes
Other ________			Other ________			Other ________		
HSA/EBT	☐ No	☐ Yes	Probation	☐ No	☐ Yes	Drug Court	☐ No	☐ Yes
Name ________			Name ________			Name ________		

Community Support Services

☐ Employment	☐ SSI Application	☐ SSDI Application	☐ EBT	☐ Shelter	☐ HDAP
☐ Mental Health	☐ Therapist	☐ Support Group	☐ NAMI	☐ Medication	☐ Treatment
☐ Inpatient Program	☐ Outpatient Program	☐ Sober Living/SLE	☐ NA Group	☐ AA Group	☐ Sponsor
☐ Credit Repair	☐ Housing Search	☐ Rental Applications	☐ Deposit	☐ Furniture	☐ Clothing
☐ Room Rental	☐ Emerson House	☐ Rochester House	☐ His Way	☐ ARC	☐ THCC
☐ Transportation	☐ Homeless Court	☐ Community Service	☐ Legal Help	☐ Probation	☐ CPS
☐ Domestic Violence	☐ Family Reunification	☐ Education/ GED	☐ HIV/AIDS	☐ Disabled	☐ Seniors
☐ ________	☐ ________	☐ ________	☐ ________	☐ ________	☐ ________

Housing Needs and Preferences

Number of adults in the household _________ Number of children in the household __________ Roommates __________

Location, in order of preference:	**Preferred size**:	**Special Needs:**
(1) ____________________	☐ Studio	☐ Close to public transportation
(2) ____________________	☐ One bedroom	☐ One level unit
(3) ____________________	☐ Two bedroom	☐ Yard or nearby park
(4) ____________________	☐ Three bedroom	☐ ADA accommodations
(5) ____________________	☐ Other ____________	☐ Close to ____________ Hospital/School

Client Housing Goal: In your own words describe what you hope to gain from Community Support Services

____

____

Client Signature ____________ **Date** ____________ **Case Manager** ____________ **Date** ____________