WAYSIDE YOUTH AND FAMILY SUPPORT NETWORK

Shortstop TLP/THP
116-118 North Street
Somerville, MA 02144
P: (617) 776-3377
F: (617) 628-3915

INTAKE ASSESSMENT AND REFERRAL FORM DATE: _____

Contact Name: _____Social Security #: _____

Age: _____ Date of Birth:_____ Place of birth: _____

Race: _____ Ethnicity (optional) _____Status in the USA:_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Pregnant ☐Yes ☐ No ☐Not Applicable

Contact Number: _____2nd Contact Number_____

Email address: _____

Referring Case Manager/Counselor:_____Phone:_____

Name of Referring Shelter/program:_____

Current Address:_____

How long have you been homeless?_____

Reason(s) for homelessness:_____
_____
_____

Are you currently enrolled in Educational Program (High School, College or Trade School):
☐Yes ☐No

Name of School and the number of hours attending: _____

Source of income: ☐Employed ☐ Unemployed ☐Benefits Please list (SSI, SSDI etc)

Benefit Source _____ Amount: _____

Employer: _____Telephone #:_____

Address: _____

How long employed? _____ Current Position: _____

Hours per week: _____ Hourly wages: _____ Monthly income:_____

Do you currently receive food stamps? ☐Yes ☐No Amount: _____

Is there any reason that you cannot currently work? _____ if yes, please explain: _____

_____

_____

_____

_____

Are you in recovery: ☐Yes ☐No If in recovery, list drug(s) of choice:_____

Length of sobriety:

_____

What ongoing services do you need to continue your sobriety?

_____

_____

Have you ever been diagnosed with mental illnesses? ☐Yes ☐No When? _____

What was your diagnosis?

_____

Have you ever been hospitalized? ☐Yes ☐No When? _____
(If yes, please explain)

_____

_____

Have you ever attempted to hurt yourself? ☐Yes ☐No When? _____
(If yes, please explain)

_____

_____

Are you currently taking any medication(s) ☐Yes ☐No: (If yes, please list)

_____

_____

Are you involved with DYS, DMH, DCF? ☐Yes ☐No (if yes which type):_____
Briefly Explain situation:

_____

_____

Are you receiving counseling? ☐Yes ☐No if yes name and phone number of Therapist/Psychiatrist:

_____

Do you have Medical Insurance? ☐Yes ☐No if yes what type:
_____

Are you enrolled on a parent or guardians health Insurance? ☐Yes ☐No if yes, will you remain on

their insurance or will you be required to obtain you own health insurance please

explain:_____

_____

Do you have any adults in your life that you feel are supportive of you? ☐Yes ☐No (if yes who are these individuals and how are they supportive?)

_____

_____

_____

Are you involved with the legal system? ☐Yes ☐No ☐Pending
(If yes or Pending What are the Charge/Charges?)

_____

Are you on parole? ☐Yes ☐No if yes wrap-up dates: _____

Are you on probation? ☐Yes ☐No if yes wrap-up dates: _____

Do you have any Charges that involve you being registered as a Sex Offender? ☐Yes ☐No

What are the circumstances of this Charge? :

_____

_____

_____

What are your permanent housing goals and what type of housing does this include?

_____

_____

_____

_____

_____

Are you currently working with other social services programs? What agencies and types of services?

_____

_____

_____

What are your three main goals during your transitional stay?

1. _____

2. _____

3. _____

What do you think our transitional program can offer you?

_____

_____

_____

_____

_____

Do you have any additional contact numbers or email addresses that you would like us to use in contacting you?

Client Signature: _____ Date:_____