**Supportive Housing Client Intake Form**

BeeVines Independent Living Community  
Participant Intake & Enrollment Application

Date of Intake: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
🧾 Referral Agency/ Name of Referrer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participant Information**

* Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Age: \_\_\_\_\_\_
* Social Security Number (Last 4 digits): \_\_\_\_\_\_\_\_\_
* Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to say
* Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Emergency Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Living Situation**

* ☐ Homeless
* ☐ Couchsurfing / Staying with others
* ☐ Transitional Housing
* ☐ Jail/Prison Release
* ☐ Hospital / Rehab
* ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral Source (If Applicable)**

* ☐ Self
* ☐ Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* ☐ Parole/Probation
* ☐ Hospital or Treatment Center
* ☐ Family/Friend
* Referring Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Phone/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Brief Summary of Situation / Reason for Housing Need**

**Medical & Mental Health History (List Below)**

**Mental health diagnosis (if any):**

* Substance use history (if any):  
  ☐ Alcohol ☐ Drugs ☐ None  
  If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal Background**

* Are you currently on parole or probation? **(List PO Name/Phone Number)**  
  ☐ Yes ☐ No
* Are you a registered sex offender?  
  ☐ Yes ☐ No

**Income Information**

* Do you have a source of income?  
  ☐ Yes ☐ No  
  ☐ SSI ☐ SSDI ☐ Employment ☐ Other: \_\_\_\_\_\_\_\_\_\_
* Monthly Income Amount (if any): $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Housing Preferences or Needs**

* Any disabilities or accommodations needed?  
  ☐ Yes ☐ No — If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Preferred Room Type:  
  ☐ Shared Room ☐ Private Room (if available)

**Independent Living & Functionality Acknowledgment**

Our program is designed for individuals who are high-functioning and capable of living independently. This is not a personal care home, nursing home, or assisted living facility. We do not provide medical care, personal assistance, or supervision.

You must be able to manage your own:

* **Personal hygiene and grooming**
* **Meal preparation and eating**
* **Medication (unless managed by an outside provider)**
* **Mobility and transportation arrangements**
* **Housekeeping and laundry**
* **Daily living responsibilities**

If you require medical or personal care services, they must be provided by a licensed outside agency or caregiver, arranged and paid for separately.

Can you live independently and manage your Activities of Daily Living (ADLs) without assistance?  
☐ Yes  
☐ No – Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently have or need a home health care provider or outside support service?  
☐ Yes – Agency Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
☐ No

☐ I understand and agree that this program provides housing only. I will be responsible for my personal care, medical needs, and daily living tasks. I will not hold the program responsible for services outside the scope of independent housing.

Participant Initials: \_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Program Agreement Preview**

☐ I understand that if accepted, I must follow all house rules, expectations, and participate in case management or program-related check-ins.  
☐ I acknowledge that violating rules may result in a strike or dismissal from the program.

**Applicant Declaration**

I certify that the above information is true to the best of my knowledge. I understand that this intake does not guarantee placement, and my application will be reviewed by staff.

Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Staff Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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