## Program

## Referral & Intake Form

### 1. Participant Information

Full Name: ______________________________

Date of Birth: ___________ Age: ______

Are you 16–17 years old? ☐ Yes ☐ No

If *yes,* are you court-emancipated? ☐ Yes ☐ No

Phone Number: ___________________________

Email: __________________________________

Current Address / Location: __________________________________________

Preferred Language: ______________________ Pronouns: ________________

Do all family members (including children) have a Social Security Number? ☐ Yes ☐ No

### 2. Parenting / Pregnancy Information

Pregnant: ☐ Parenting: ☐ Both: ☐

Estimated Due Date: _________________

Prenatal Care Provider: _____________________________________

High-risk pregnancy concerns? ☐ Yes ☐ No

If yes, describe: __________________________________________

Name(s) & Age(s) of Children: ________________________________________

Are all children under age 5? ☐ Yes ☐ No

### *Custody Verification*

Do you have legal/official documentation showing primary custody of your child(ren)?

☐ Yes

☐ No

☐ Not sure

If yes, is documentation available to upload or bring to intake?

☐ Yes

☐ No

*(Note: Custody documents are required for program eligibility. Staff can support you in obtaining replacements if needed.)*

### *Child Development Screening (ASQ / ASQ-SE)*

Has your child(ren) received a developmental screening?

☐ Yes ☐ No ☐ Not sure

Documentation Available (if screened): ☐ Yes ☐ No

Notes: ______________________________________

If no or not sure, screenings will be completed as part of the Hope Haven program.

## 3. Housing & Safety Assessment

Housing Situation: ☐ Unsheltered ☐ Couch-Surfing ☐ Shelter ☐ Transitional Housing

☐ At Risk of Losing Housing ☐ Other: _________________

*Safety Concerns:*

☐ Domestic/intimate partner violence ☐ Unsafe environment

☐ Threat of family violence ☐ No current concerns

Safety Notes: ____________________________________

## 4. Reason for Referral

☐ Experiencing homelessness

☐ At risk of homelessness

☐ Need for supervised/supportive living

☐ Economic hardship

☐ Limited family/parenting support

☐ Need for life skills development

☐ Seeking stability for children under 5

☐ Other: ______________________________

### 5. Support Needs

☐ Safe, stable housing (up to 12 months)

☐ Case management ☐ Life skills development

☐ Economic stability support ☐ Parenting education

☐ Prenatal or postpartum support

☐ Mental health services ☐ Substance use support

☐ Childcare assistance / referrals

☐ Access to benefits (WIC, CalWORKs, Medi-Cal, CalFresh)

☐ Education support ☐ Employment support

☐ Transportation assistance

☐ Other: ______________________________

### 6. Referring Agency / Individual

Referrer Name: ____________________________

Organization: ______________________________

Phone: ________________ Email: ________________

Relationship to Participant: _______________________

### 7. Consent to Share Information

☐ I authorize SOH to receive/share my information for eligibility and services.

Participant Signature: ___________________________________________ Date: _________

Referrer Signature: ______________________________________________ Date: _________

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### Office Use Only

Date Received: ________________

Intake Staff: __________________

Eligibility Status: ☐ Approved ☐ Pending ☐ Waitlist ☐ Not Eligible

Eligibility Notes: ______________________________________________

Assigned Case Manager: ____________________________

Program Entry Date: _______________________________