HEALING HEARTS OF FAMILIES U.S.A. MINISTRIES INC.

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404-289-5277 Fax: 404-393-8933

INTAKE FOR HELP

Date: _____

Print Your Information clearly:
Name: First _____ Last _____ Middle _____

Address:_____ *Last day lived here*: _____

City: _____ State: _____ Zip: _____

Contact Number (s) Ph/Cell: _____ ( ) Mine ( ) Message # **Email:** _____

D.O.B.: _____ Age: _____ ( ) M/ ( ) F SS # just the last 4 _____

You can skip the parts of this form that do not pertain to you or place N/A in the space.

Are you the primary caregiver of children under age 18 who live with you: ( ) Yes ( ) No
What are the ages of your children: Boys Age _____ / Girls Age _____

Where do you live: ( )-Apartment ( )-Home ( )-Shelter ( )- Homeless One night or more /
I live ( )- Alone ( ) With Children ( ) With Friends/Relatives ( ) Incarcerated homeless

This was a referral from: ( ) Myself ( )Agency ( ) Friend Name: _____
Contact Number: _____ Faith Organization ( ) Name: _____

History: *Domestic Violence:* ( ) Yes ( ) No / *Previous Incarceration*: ( ) Yes ( ) No

Check Your Needs : ( ) CHILDCARE ( ) CLOTHING ( ) FOOD ( ) FURNITURE ( ) JOB
( ) FINANCIAL For what _____ ( ) MENTAL HEALTH CARE ( ) HOUSING ( ) JOB SKILLS
( ) LEGAL ( ) STORAGE ( ) TRANSPORTATION ( ) ID Type: _____ ( ) SAFE
SHELTER FOR MYSELF ( ) MYCHILDREN ( ) OTHER NEEDS: _____

Describe incident or issue that led to your need for assistance: _____

_____

_____

I am trying to piece together my needs from various sources and those needs for my survival accounts for $_____ monthly. I am short of that need by $ _____ this month.

Recommendation/Plan: _____

_____

Intake By: _____ *Date:* _____
\Were we able to help this person/family? ( ) Yes ( ) No *(AWC)* _____

Do you use drugs or alcohol more than once a week ( ) n the past year? Yes ( ) No ( ) / Current Use ( )
Are you working? Yes ( ) No ( ) Where? _____ Hours _____ to _____
Total Monthly Income: _____ Type of income: _____

Do you have your own transportation Yes ( ) No ( )
Do you have a computer ( ) Yes ( ) No / Access to internet ( ) Yes ( ) No
Can you return to a family home? Yes ( ) No ( ) Maybe ( ) I do not want to ( )

Have you ever had your children removed from your home Yes ( ) No ( ) if yes do you have a relationship with the person who cares for your child(ren)? _____ Are they relatives( ) Other ( )

Do you have COVID ( ) Yes ( ) No ( ) Tested + ( ) Family had it ( ) Family died from it

Are you dealing with ( ) Grief ( ) Anxiety ( )Sad ( )Worried over 1 month/ from what?
_____

YOUR EMERGENCY CONTACT- someone who knows how to contact you.

2.) Name: _____ Phone: _____ Relationship: _____
Address: _____ City _____ State _____ Zip _____

Do you think it would benefit you to have someone to help you with family matters during a resolution/transition process? ( ) Yes ( ) No ( ) Don't Know

Do you have or have you tested positive for COVID? _____Are you under stress related to COVID ? ( ) Yes ( ) No if yes please explain, _____
_____ _____
Do you need or want Protection Products i.e mask sanitizer etc? _____

Please answer this, what I really need help with over the next three months is
_____
_____

I understand and agree that my information in part will be shared only with organizations that may provide assistance to me or my family and I agree to have it shared. _____ ( ) Yes ( ) No

_____ _____
Consumer Signature **Date**

www.healingheartsusa.org **Email:healinghearts_us@yahoo.com**
Fax 404-393-8933

Intake Date: _____ Fee Due ( ) Yes ( ) No Paid: _____