Sioux Empire Network of Care
Common Intake Form

Date: _____/_____/_____

CLIENT RECORD & CLIENT DEMOGRAPHICS

Name:_____
First **Middle** **Last**

Alias(s): _____

Social Security Number: _____-_____-_____ ☐ Client doesn't know ☐ Client Refused ☐ Data not collected

Date of Birth: _____/_____/_____

Veteran: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused ☐ Data not collected

Gender: ☐ Female ☐ Male ☐ Transgender M to F ☐ Transgender F to M ☐ Client doesn't know ☐ Client Refused ☐ Data not collected

Primary Race: ☐ American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Client doesn't know ☐ Client Refused ☐ Data not collected ☐ Other_____

Ethnicity: ☐ Hispanic/Latino ☐ Non- Hispanic/Latino ☐ Client doesn't know ☐ Client Refused ☐ Data not collected

Marital Status: ☐ Single (never married) ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Client doesn't know ☐ Client Refused ☐ Data not collected

Are you a single parent? ☐Yes ☐ No

Number of children under 18 (in your care) _____

Highest Level of Education Attained: ☐ Less than High School Diploma ☐ High School Diploma/GED ☐ Some College ☐ Technical School ☐ College Degree ☐ Grad School ☐ Client Refused ☐ Data not collected

ADDRESS INFORMATION

Address Type: ☐ Both – Physical / Mailing ☐ Physical ☐ Mailing ☐ Homeless

Current Address: _____ _____
City, State, Zip

CONTACT METHOD

Phone Number: (_____)_____ ☐ Home Phone ☐ Cell Phone ☐ Message Phone **ONLY** ☐ No Phone

Can we **send community give away and event information alerts via text messages to this number**? ☐ Yes ☐ No

Email Address: _____

DISABILITIES

Does the client have a disabling condition? : ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused ☐ Data not collected

If yes, Check all that apply: ☐ Physical ☐ Mental Health ☐ HIV/AIDS ☐ Chronic Health ☐ Vision Impaired ☐ Hearing Impaired ☐ Hepatitis C ☐ Developmental ☐ Client Refused ☐ Other_____

EMPLOYMENT INFORMATION

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ SSDI ☐ Temporary / Day Labor ☐ Seasonal Work

Employer Name: _____

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helpline center
SIOUX EMPIRE NETWORK OF CARE

Covered by Health Insurance: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused ☐ Data not collected

Reason for Visit:_____

Full Legal Name of those* ***residing in your household*** **(first, middle ,last)**	**Date of Birth**	**Gender (M, F, T)**	**Relationship to Applicant**

***Please verify with agency if budget needs to be completed**

INCOME	
Income One:	$
Income Two:	$
Income Other:	$
TOTAL MONTHLY INCOME	$

EXPENSES	
Housing (Mortgage / Rent Payment)	$
Food	$
Electric	$
Gas / Heat	$
Water	$
Garbage	$
Medication	$
Medical / Payments	$
Health / Life Insurance	$
Taxes	$
Child Support	$
Child Necessities (Diapers, School lunches, School supplies etc.)	$
Cable / Internet	$
Telephone / Cell Phone	$
Auto Payment	$
Auto Insurance	$
Auto Fuel / Bus Pass	$
Other Expenses	$
TOTAL MONTHLY EXPENSES	$

OUTSTANDING DEBTS	Monthly Payment Amount	Total Amount Owed
Medical Bills	$	$
Pay Day Loans / Pawn Tickets	$	$
Title Loan	$	$
Delinquent Child Support	$	$
Delinquent / Previous Landlord	$	$
Delinquent Utility Bill	$	$
Rent to Own	$	$
Payments to County	$	$
Student Loan	$	$
Fines / Restitution	$	$
Delinquent / Previous Rent or Mortgage	$	$
Credit Card	$	$
Auto Loan	$	$
Other Debts	$	$
TOTAL MONTHLY PAYMENT(S)	$	$
TOTAL AMOUNT OWED	$	$

ALL INFORMATION MUST BE ENTERED INTO SENC THE SAME DAY OF CLIENT INTAKE