



SOLUTIONS TO END POVERTY SOON - (STEPS) INTAKE FORM

Date: _____

First Name: _____ Middle Name: _____

Last Name: _____ Suffix: _____

Date of Birth (mm/dd/yyyy): _____ Social Security number: ____-____-____

Full Approximate or Partial Client Doesn't Know/Don't Have Client Refused

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

Family Size _____ Head of Household's Full Name _____

Citizen __ Yes __ No __ (Green Card __)

Tell Us about Your Last Permanent Address (*where you last lived for 90 days or more*)

City _____ County _____ State _____

Phone Number _____ Cell Phone Number _____

Email _____ Contact Preference _____

Gender: Male Female Transgender Male to Female Transgender Female to Male

Doesn't identify as male, female, or transgender Client Doesn't Know Client Refused

Race (choose all that apply):

American Indian or Alaska Native

Asian

Black or African American

Hispanic/Latino

Native Hawaiian or Other Pacific Islander

White

Client Refused

Client doesn't know

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Veteran Status: (Served/Serving in US Military): Yes No
 Client Doesn't Know Client Refused

Are You Homeless? (Housing Status):

- Category 1- Homeless
- Category 2- Imminently losing housing
- Category 3- Homeless under other Federal statutes
- Category 4- Fleeing domestic
- Stably housed
- At risk of losing housing
- Client Doesn't Know

Income & Benefits - Income Source (Choose all that applies)

Earned Income (i.c. employment income) \$ _____

Unemployment Insurance \$ _____

Supplemental Security Income (SSI) \$ _____

Social Security Disability Income (SSDI) \$ _____

Veteran's Service-Connected Disability Compensation \$ _____

Veteran's Non-Service-Connected Disability Compensation \$ _____

Private Disability Insurance \$ _____

Worker's Compensation \$ _____

Temporary Assistance for Needy Families (TANF) \$ _____

General Assistance (GA) \$ _____

Retirement Income from Social Security \$ _____

Pension from Former Job \$ _____

Child Support \$ _____

Alimony/Other Spousal Support \$ _____

Aid to the Needy and Disabled (AND) \$ _____



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Income & Benefits - Income Source (Choose all that applies)

Old Age Pension (OAP) \$ _____

Other Sources \$ _____

Client Doesn't Know Client Refused

Non-Cash Benefits (Choose all that applies)

None _____ Client Doesn't Know _____ Client Refused _____

Other Benefit Source (amount optional)

Food Stamps/SNAP Yes No \$ _____

TANF Child Care Yes No \$ _____

Temporary Rental Assistance TANF Yes No \$ _____

Transportation Services Yes No \$ _____

Section 8 or Rental Assistance Yes No \$ _____

WIC (Women, Infants and Children) Yes No \$ _____

Other TANF-funded Services Yes No \$ _____

HEALTH INSURANCE

Health Insurance Yes No

MEDICAID/ MEDICARE Yes No

Veterans - VA Medical Other Yes No

Client Refused

Are you currently living in subsidized housing or are you currently receiving rental assistance? Yes No If yes, what program? _____

How long have you lived at your current residence? _____ Months _____ Years
Do you rent or own? Rent Own

What caused you to fall behind in your monthly rent? **(CIRCLE ALL THAT APPLY)**

Medical Emergency Loss or Delay in Benefits Loss of Income Natural Disaster (fire, flood, etc.) Pandemic

Unexpected/Unusual Expense (Explain): _____



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Permanent Change in Household Composition Domestic Violence (if yes, is there a current restraining Order)

Other: _____

Do you have an eviction summons or a warrant of removal from the court with a docket number on it? Yes NO

If yes, please provide docket #/ court date/lock out date? _____

How much do you owe? _____

Have you applied for assistance from any other program? Yes NO

If yes, where _____

When do you expect to hear from them? _____

I, the undersigned authorize the release of Social Services/Medical/Educational records

On _____ to

SOLUTIONS TO END POVERTY SOON. I also grant permission to SOLUTIONS TO END POVERTY SOON and it's agents to discuss my case with Social Service. Education and Health care professionals, and to release pertinent information when necessary in order to assess needs, develop and impliment a coordinated service plan.

Client Name

Date

