

**Participant ID (STAFF ONLY)**



**Referral Agency**

### Community Partners Response Participant Information

I am currently receiving the following services and supports (check all that apply):	<input type="checkbox"/> Education Services <input type="checkbox"/> Employment Services <input type="checkbox"/> Food Services <input type="checkbox"/> Housing Services <input type="checkbox"/> Legal Services <input type="checkbox"/> Medical Services		<input type="checkbox"/> Mental Health Services <input type="checkbox"/> Substance Use Services <input type="checkbox"/> Transportation Services <input type="checkbox"/> Other Specify: _____ <input type="checkbox"/> NA/None <input type="checkbox"/> Prefer Not to Answer	
	<input type="checkbox"/> Aid to Dependent Children/TANF <input type="checkbox"/> Childcare subsidy/Title XX <input type="checkbox"/> Food Stamps (SNAP) <input type="checkbox"/> Housing Voucher/Section 8 <input type="checkbox"/> Medicaid <input type="checkbox"/> Unemployment		<input type="checkbox"/> Utilities Assist/LIHEAP <input type="checkbox"/> WIC <input type="checkbox"/> Other: _____ <input type="checkbox"/> NA/None <input type="checkbox"/> Prefer Not to Answer	
What is your current housing status?	<input type="checkbox"/> Homeless <input type="checkbox"/> At-risk of homelessness	<input type="checkbox"/> At-risk of losing housing <input type="checkbox"/> Fleeing Violence	<input type="checkbox"/> Stably Housed	
Are you a veteran or have active-duty military status?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
What is your highest level of school completed?	<input type="checkbox"/> Less than high school <input type="checkbox"/> High school diploma or GED <input type="checkbox"/> Some college, no college <input type="checkbox"/> Certificate or trade credential		<input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Graduate or professional degree <input type="checkbox"/> Prefer not to answer	
Are you a domestic violence survivor?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
If yes, when did the experience occur?	<input type="checkbox"/> Within past three months <input type="checkbox"/> 6 to 12 months		<input type="checkbox"/> Three to six months <input type="checkbox"/> More than a year ago	
If yes, are you currently fleeing?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Do you struggle with any of the following?	<input type="checkbox"/> Injured Brain <input type="checkbox"/> Language Barriers <input type="checkbox"/> Emotional Neglect <input type="checkbox"/> Behavioral/Mental Health <input type="checkbox"/> Chronic Health Issues		<input type="checkbox"/> Alcohol Use <input type="checkbox"/> Substance Use <input type="checkbox"/> Both Alcohol/Substance Use <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Physical Mobility <input type="checkbox"/> Developmental	
<b>Is there someone who doesn't live with you we can contact if we can't reach you?</b>				
<input type="checkbox"/> Yes, please list below	<input type="checkbox"/> No	<input type="checkbox"/> Unsure		<input type="checkbox"/> Prefer not to say
<b>Name</b>	<b>Relationship to you</b>		<b>Phone</b>	
Do any of your children have a disability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how many: _____	
Do you or your children QUALIFY for Medicaid, Title XX, and/or free and reduced lunch, even if you don't receive any of them?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure <input type="checkbox"/> Prefer Not to Say	
Do you currently have an open case with the DHHS Child Welfare system (this will not affect your eligibility):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	