Society of St. Vincent de Paul

General Intake Form

Initial Contact Date _____ Home Visit Date _____

Home Visit Team _____

Telephone _____ Email Address _____

Client Information

General Information

Client Name _____ Spouse / Other _____

Client DOB _____ Spouse / Other DOB _____

Client Profession _____ Spouse / Other Profession _____

Current or New Address (if moving) _____

City _____ State _____ Zip _____

Telephone _____ Email Address _____

Family / People Living at the Residence

Name _____ Age ____ Sex _____Relationship _____

School or Employer _____

Name _____ Age ____ Sex _____Relationship _____

School or Employer _____

Name _____ Age ____ Sex _____Relationship _____

School or Employer _____

Name _____ Age ____ Sex _____Relationship _____

School or Employer _____

Name _____ Age ____ Sex _____Relationship _____

School or Employer _____

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What are the immediate needs of the person / family?

How did the person / family find out about the Society of St. Vincent de Paul Conference?

Has the person / family in need requested assistance from another organization and, if so, which one's and what were the results?

Ask the person / family in need to describe the relationship they have with their extended family. Are they able to assist in any way (spiritual, emotional, financial, other physical assistance)? If so, briefly describe which family member(s) provides assistance and what type of assistance they provided.

Do you or anyone in your family have disabilities or special needs which require special accommodations? Yes ☐ No ☐ If yes, explain below:

Based upon the initial intake information provided by the family and / or review of their financial statement, should the family be referred to other resources that may assist them maintain a more stable home? If so, explain the resources needed

Have you and the family / individual set any goals to help them move towards self-sufficiency? (attending classes, counseling, special training, legal aid, etc.) ***Yes*** ☐ ***No*** ☐ ***Please explain.***

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Monthly Income and Expense Review

Actual Monthly Income	
Client Salary	
Spouse/Significant Other Salary	
Dependent(s) Salary	
Child Support	
CalWorks Benefits	
Supplemental Security Income (SSI)	
Additional Income (please define)	
A. Other	
B. Other	
C. Other	
Savings/Checking Account Balance	
Total Monthly Income	

CalFresh Benefits
DO NOT ADD TO TOTAL INCOME ABOVE

Other Assistance / Benefit Programs
Mark "Y" for YES and "N" for NO
Childcare Assistance
Housing Assistance (Section 8, HUDD, EAPE, etc.)
Meal Programs (school lunch, Meals-On-Wheels, etc.)
Transportation Assistance
Utility Discount Programs (HEAP, CARE, etc.)
Other (food banks, other non-profits, etc.)

Average Monthly Expenses	
Rent / Mortgage	
Food (do not include CalFresh benefits)	
Telephone	
Cable/Internet Service	
Electricity	
Gas	
Water	
Transportation	
Automobile	
Automobile Insurance	
Gasoline	
Childcare	
Special Needs	
Child Support Payments	
Credit Card Debt	
Other	
Total Average Monthly Expense	

Monthly Cashflow Review / Debt-to-Income Ratio	
Total Monthly Income	
Total Monthly Expenses	
Difference (+/-)	
Debt-to-Income Ratio (expense/gross income = %)	

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Visiting Team Recap & Recommendations and Internal Conference Group Worksheet

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