Clear Form

Emergency Shelter Assistance Intake Form

Safety Net Program • Emergency Housing Assistance
Aging, Disability, and Veterans Services Division

Multnomah County

Date | Referral Source | Name | Phone | Agency - Select | Other

Applicant Information

Name • Last | First | MI | Social Security #

DOB | Phone | Medicaid # | Gender ☐ Female ☐ Male ☐ Transgender

Is applicant homeless? ☐ YES ☐ NO If yes, for how long?

Permanent Address

Apt Bldg Name | Address | City | State | Zip

Total number in household =

of children

*Please specify all other household members not already listed (name/DOB/relationship to applicant)

☐ Single individual ☐ Couple ☐ Parent(s) with child(ren)

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Not Reported

Race (check all that apply)

☐ White ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Asian
☐ Black or African American ☐ Other (specify) ☐ Not reported or Unknown

Veteran Status

Has applicant ever served in the military? ☐ YES ☐ NO

Is applicant the surviving spouse of someone who served in the military? ☐ YES ☐ NO

Is applicant in receipt of any veterans' benefits? ☐ YES ☐ NO

Monthly Income

Applicant $ | Source

Other household member $ | Source

Total household income $ 0.00

Does applicant receive Supplemental Nutrition Assistance Program Benefits (SNAP)? ☐ YES ☐ NO

Emergency Shelter Type Requested

☐ **Adult Care Home** Operator or Name

Address | City | Zip

Phone | Fax | Email

Start date | Has a Medicaid services referral been made? ☐ YES ☐ NO

☐ **Motel** Motel name

Address | City

Start date | Phone | Fax

Circumstances of Request and Housing Plan

1. Describe circumstances that led to need for emergency shelter assistance

2. Can the applicant stay in a shelter? ☐ YES ☐ NO If no, please explain

3. Is applicant at risk (please explain)

4. What is the applicant's housing plan?

FOR CENTRAL ADVSD USE ONLY

ADVSD Authorization | Date

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I am requesting one-time financial assistance, and certify the foregoing statements are true and correct to the best of my knowledge. I understand that the above information may be released to agencies within the Aging, Disability & Veterans Services (ADVSD) Network, as needed, in determining eligibility and/or providing services to my family and me. I also authorize Multnomah County ADVSD to speak to my payee about financial information and my landlord regarding payment information. The information provided here is subject to verification by authorized local or federal officials.

We, the undersigned, have participated in the development of this Housing Case Plan.

I hereby authorize the release of the above information for the purpose of evaluating my request for assistance and for further follow-up research.

Applicant Signature	Date

Interviewer Signature	Date	Agency and/or Phone

☐ Check here for electronic signature

Please email this completed PDF (2 pages) to

ADVSD Special Medical Needs Assistance Program

EMAIL (secure) • advsd.safetynet@multco.us