ELAYNE & JAMES SCHOKE
JEWISH FAMILY SERVICE
OF FAIRFIELD COUNTY

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CASE MANAGEMENT INTAKE FOR FAIRFIELD COUNTY RESIDENTS

Referral Date: ______________________ Referred By: _____________________________
(Date you are submitting Case Management Intake) (Person/Agency who recommended our services to you)

Primary Reason for Completing Intake:____

Full Name: ____

Date of Birth: __________________ Age: ______ Gender: ____________

Street Address____ Apt/Suite/Unit________________

City___________________ State___________ ZIP_____________

Cell Phone: _________________ Home Phone: ________________ Email: ________________________

How do you prefer we contact you? ____Phone Call ____Voicemail ____Text Message ____Email
(Check all that apply)

Race: _____________ Ethnicity: ____________ Religion: ______________

Dietary restrictions: ____ Kosher ____Halal ____Vegan ____Vegetarian

Are you or your parents Holocaust Survivors? ____ Yes, myself ____ Yes, my parent ____ No

If yes, what is the claims conference ID number? ____________________________________

Primary language spoken: ________________

Do you have difficulty understanding English? ____ Yes ____ No

Do you have difficulty using English to navigate health and social service systems? ____ Yes ____ No

Relationship Status: ____Single ____Married ____Separated ____Divorced ____Widowed ____Other

Living Situation: ____ Rental ____Own Home ____Other_________________________

Are you living in **temporary**, **unsafe**, and/or **inadequate** housing? ____ Yes ____ No

Emergency Contact: Name__________________________________

Cell Phone______________ Relationship _______________

HOUSEHOLD COMPOSITION: PLEASE LIST ALL HOUSEHOLD MEMBERS, INCLUDING YOURSELF

SENIORS (60+)

Name	Relationship	Date of Birth	Gender	Employed?

ADULTS (18-59)

Name	Relationship	Date of Birth	Gender	Employed?

CHILDREN (0-17)

Name	Relationship	Date of Birth	Gender	School Grade

Do you have any pets? ____ Yes ____ No

SUPPORT SYSTEM LIVING OUTSIDE OF HOUSEHOLD (partners, children, other close supports)

Name	Relationship	Date of Birth	Gender	City, State

Do you have a functioning support system? ____ Yes ____ No

TOTAL MONTHLY INCOME SOURCES & BENEFITS

Alimony	$________________	Short Term Disability	$________________
Child Support	$________________	Social Security	$________________
Disability Ins. Inc.	$________________	Social Security Disability Insurance (SSDI)	$________________
Employment	$________________	Supplemental Nutrition Assistance Program (SNAP)	$________________
HIV/AIDS Service Administration	$________________	Supplemental Security Income (SSI)	$________________
Long Term Disability	$________________	Survivor Benefits	$________________
Pension	$________________	Unemployment Insurance	$________________
Public Assistance	$________________	Veteran's Assistance	$________________
Rent Supplement	$________________	Workman's Compensation	$________________
WIC ________________	$________________	Other__________________	$________________

Total Household Monthly Income: $______________

Do you have a regular source of income? ____ Yes ____ No

Do you have difficulty meeting monthly expenses? ____ Yes ____ No

Are you receiving any case management services through another agency? ____ Yes ____No

NON-MEDICAL SERVICE PROVIDERS

(i.e. Advocacy, Case Management, Housing, Food)

Agency	Contact Person	Phone	Email	Service