

Supportive Housing Client Intake Form

Pathway Living, LLC
Participant Intake & Enrollment Application

Date of Intake: _____

 Referral Agency/ Name of Referrer: _____

Participant Information

- Full Name: _____
- Date of Birth: _____
- Age: _____
- Social Security Number (Last 4 digits): _____
- Phone Number: _____
- Email Address: _____
- Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to say
- Emergency Contact Name: _____
- Relationship: _____
- Emergency Contact Phone: _____

Current Living Situation

- ☐ Homeless
- ☐ Couchsurfing / Staying with others
- ☐ Transitional Housing
- ☐ Jail/Prison Release
- ☐ Hospital / Rehab
- ☐ Other: _____

Referral Source (If Applicable)

- ☐ Self
- ☐ Agency: _____
- ☐ Parole/Probation
- ☐ Hospital or Treatment Center
- ☐ Family/Friend
- Referring Contact Name: _____
- Phone/Email: _____

Brief Summary of Situation / Reason for Housing Need

Medical & Mental Health History (List Below)

-
-
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Mental health diagnosis (if any):

- Substance use history (if any):
☐ Alcohol ☐ Drugs ☐ None
If yes, explain: _____

Legal Background

- Are you currently on parole or probation? **(List PO Name/Phone Number)**
☐ Yes ☐ No
- Are you a registered sex offender?
☐ Yes ☐ No
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Income Information

- Do you have a source of income?
☐ Yes ☐ No
☐ SSI ☐ SSDI ☐ Employment ☐ Other: _____
- Monthly Income Amount (if any): \$ _____

Housing Preferences or Needs

- Any disabilities or accommodations needed?
☐ Yes ☐ No — If yes, explain: _____
- Preferred Room Type:
☐ Shared Room ☐ Private Room (if available)

Independent Living & Functionality Acknowledgment

Our program is designed for individuals who are high-functioning and capable of living independently. This is not a personal care home, nursing home, or assisted living facility. We do not provide medical care, personal assistance, or supervision.

You must be able to manage your own:

- **Personal hygiene and grooming**
- **Meal preparation and eating**
- **Medication (unless managed by an outside provider)**
- **Mobility and transportation arrangements**
- **Housekeeping and laundry**
- **Daily living responsibilities**

If you require medical or personal care services, they must be provided by a licensed outside agency or caregiver, arranged and paid for separately.

Can you live independently and manage your Activities of Daily Living (ADLs) without assistance?

☐ Yes

☐ No – Please explain: _____

Do you currently have or need a home health care provider or outside support service?

☐ Yes – Agency Name (if applicable): _____

☐ No

☐ I understand and agree that this program provides housing only. I will be responsible for my personal care, medical needs, and daily living tasks. I will not hold the program responsible for services outside the scope of independent housing.

Participant Initials: _____ Date: _____

Program Agreement Preview

☐ I understand that if accepted, I must follow all house rules, expectations, and participate in case management or program-related check-ins.

☐ I acknowledge that violating rules may result in a strike or dismissal from the program.

Applicant Declaration

I certify that the above information is true to the best of my knowledge. I understand that this intake does not guarantee placement, and my application will be reviewed by staff.

Participant Name: _____

Participant Signature: _____

Date: _____

Staff Name: _____

Signature: _____

Date: _____