Live United Village
600 N. Highway 17-92, Suite 130
Longwood, FL 32750
(407) 260-9155
www.thesharingcenter.org

REACH **INSPIRE** **SUSTAIN** **EMPOWER**

ProjectRISE Participant Intake and Assessment Form

_____ _____
Date: HMIS#:

_____ _____
First Name: Last Name:

_____ _____
Social Security#: Date of Birth

_____ _____ _____
Address City State/Zip

_____ _____ _____
County Age Phone #

How do you identify? Female Male Transgender M/F F/M Gender non-conforming
Questioning Prefer Not to Answer

Race: (Choose all that apply) American Indian, Alaska Native or Indigenous
Asian or Asian American
Black, African American, African
Native Hawaiian or Pacific Islander
White
Other
Prefer Not to Answer

Ethnicity (Must choose one) Hispanic/Latin (o) (a) (x)
Non-Hispanic
Prefer Not to Answer

Are you a U.S. Veteran? Yes ____ No ____

Have you previously been employed? Yes ____ No ____
If no, please provide a reason:

Staff Signature_____Date_____

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Not looking	Unable to work due to health	Laid Off due to COVID	Homelessness	Other

Are you willing to actively participate with ProjectRISE four (4) week program?
Yes ____ No ___

Employment History:

Previous Employer	Length	Reason for Leaving

Are you currently experiencing Homelessness? ____ Do you have a Housing Plan? _____
Have you experienced homelessness within the past 4 years? Yes ___ No ___
No. of times _____ Length _____ County of origin _____
What is your household size?
Adults_____ Children_____ (under 18 years) DCF Case _____

Do you currently receive any of the following mainstream benefits?

Source	Yes	No	Amount
SSI			
SSDI			
Retirement			
Military			
Medicaid			
Medicare			
AFDC			
Private Health			
Food Stamps			
Child Support			
Other			

Do you have a chronic medical condition? Yes _____ No _____
Have you ever received Mental Health treatment or service? Yes _____ No _____

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Mental Health Provider:

_____

Do you have a history of Substance abuse? Yes_____ No _____

If yes, please list substances and last use:

Substance	**Last Used**

Upon your return, will you need any of the following:

Inpatient Treatment	Outpatient Treatment	Sober Living	Support Group

Incarceration History: Number of Incarcerations: _____

Year	Charges	Length	Location

Have you been sentenced? Yes ____ No____ Next Court Date:_____

Upon your return or are you currently on Probation? Yes _____ No_____

Length _____

Will you need any of the following?

Document	Yes	No	
State ID			
Driver's License			
Social Security Card			
Birth Certificate			State Issued:

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_____
Emergency Contact:

_____ _____
Relationship: Phone:

_____ _____ _____
Contact Address: City: State/Zip:

_____
Staff Signature:

_____
Date:

Office use only:
Accepted into program: Yes _____ No _____
Reason for denial and/or comments:

Staff Signature_____Date_____