Illinois Department of Veterans' Affairs
Prince Homeless and Disabled Program
One Veterans Drive
Manteno, Illinois 60950
(815) 468-6583
(815)-468-9965 fax

Intake Form

	Date:
Full Name:	Birthdate:
Contract/Referral Person:	Phone: ( )
Contact Address:	

Sex: ☐ Male ☐ Female	SSN:	Marital Status:
Highest Level of Education: ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18		
Insurance: ☐ Yes ☐ No	Medicaid #:	Medicare #:

Referral Source: Put an X in the Box that applies to your referral.	
☐	Self Referral
☐	Veteran Assistance Commission (Name/town):
☐	P.A.D.S. (Indicate town):
☐	Shelter Program (Name/town):
☐	VA Hospital (Name/Program):
☐	Other (please list):

Military Service:		
Branch of Service:	Discharge Type:	
Enlistment Date:	Discharge Date:	Copy of 214: ☐ Yes ☐ No
Served in Combat: ☐ Yes ☐ No	Wounded/Injured: ☐ Yes ☐ No	Served under fire: ☐ Yes ☐ No

Employment History				
Current Employment Status:	☐ Unemployed	☐ Full Time	☐ Part Time	☐ Temporary
Current or most recent position held, include dates and reason for leaving:				
What is the longest period of time you have been able to hold a job?				
Do you plan to actively seek employment?			☐ Yes	☐ No
Do you have vocational training? Please explain:			☐ Yes	☐ No

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Do you have college credits?	☐ Yes	☐ No
Do you have any certifications or training in a specific type of job? If YES, please, indicate:	☐ Yes	☐ No
Do you have a current resume? If YES, please attach to intake packet	☐ Yes	☐ No

Housing History:				
Where have you slept most frequently within the last year?				
☐Shelters:	☐Transitional Housing:	☐Safe Haven(safe place to sleep):	☐Outdoors:	☐Other:
Have you been homeless within the last three years?			☐ Yes	☐ No

Finances:			
Current course of income? Put an X in the box that applies to your income source.			
☐	None		
☐	Employment		
☐	Veteran Benefits	☐ Service Connected	☐ Non-Service Connected
☐	Social Security Insurance (SSI)		
☐	Social Security Disability Insurance (SSDI)		
☐	Unemployment Insurance		
Monthly income range? Put an X in the box that applies to your income range.			
☐	None		
☐	$ 100.00 - $ 250.00		
☐	$ 251.00 - $ 500.00		
☐	$ 501.00 - $1,000.00		
☐	$1001.00 - $1,500.00		
Do you currently have a checking account?		☐ Yes	☐ No
Do you currently have a savings account?		☐ Yes	☐ No
I understand that by my signature, I am verifying the information in the entire intake packet is true and accurate. I understand that misrepresentation, falsification or material omissions of information or data during the intake			

process or while at the Illinois Department of Veterans' Affairs Prince Homeless and Disabled Program may result in my not being admitted to the Prince Program, or, if admitted, may result in my being discharged from the Prince Program. I understand that I am liable for any damages I cause to Prince property or equipment and failure to make restitution will result in Major warning(s). I also understand that I have the right to use the agency grievance process at any time during my service experience with the Prince Program.

I understand that if I am accepted as a resident of the Prince Program I will be restricted from taking an overnight pass for a minimum of 30 (thirty) days. Further I understand I will be on probation for 30 days.

Applicant's Signature:	Date:
Witness Signature:	Date:

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MEDICAL HISTORY/EMERGENCY DATA

Full Name:			Date:	
DOB:	SSN		Sex: ☐ Male ☐ Female	
Date of last Tetanus shot?				
Date of last TB Test?		Results of TB Test? (Positive or Negative)		
Have you ever had any serious accident or illnesses in the past? If yes, please explain:			☐ Yes	☐ No
Do you have any limitation of mobility or physical restrictions? If yes, please explain:			☐ Yes	☐ No
Do you have any allergies or known adverse drug reactions? If yes, please explain:			☐ Yes	☐ No
Do you have current medications you are taking or that have been prescribed, but you do not take? If yes, please explain:			☐ Yes	☐ No
Do you have any ongoing physical health problems? If yes, please explain:			☐ Yes	☐ No
Do you have dentures? ☐ Yes ☐ No		Do you wear glasses/contacts? ☐ Yes ☐ No		
Do you use a hearing aid? ☐ Yes ☐ No		Do you have any artificial limbs? ☐ Yes ☐ No		
PHYSICIAN	PSYCHIATRIST	EMERGENCY CONTACT		
Name:	Name:	Name:		
Address:	Address:	Address:		
		Relationship:		
Date:	Date:	Date:		
If hospitalized, do you want your emergency contact to be notified?			☐ Yes	☐ No

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SOCIAL HISTORY

Full Name:		Date:
DOB:	SSN:	Primary Language:

Family of Origin		
Father:		Birthdate:
Mother:		Birthdate:
Parents marital status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		
Describe our relationship with your Father:		
Describe our relationship with your Mother:		
# of siblings:	# of sisters:	# of brothers:
Name:		Birthdate:
Name:		Birthdate:
Name:		Birthdate:
Name:		Birthdate:
Name:		Birthdate:
Describe your relationship with your siblings:		

Childhood		
Where were you born?	Where did you grow up?	
How would you describe your childhood?		
Do you recall any abuse when you were a child? If yes, by whom and what type of abuse?	☐ Yes	☐ No
Did you receive any therapy (for any reason) while you were a child?	☐ Yes	☐ No
Is there any history of addiction in your family of origin? If yes, who was addicted and what were they addicted to?	☐ Yes	☐ No
Do you recall any significant loss, either through death, divorce or other means? If yes, can you recall what impact this had on you?	☐ Yes	☐ No
As a youth, did you have any involvement with the law? If yes, please explain:	☐ Yes	☐ No

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SOCIAL HISTORY
(Continued)

Describe your experience during your military career. Include the reasons for joining and reasons for getting out, positive and negative experiences, and the ways you have changed because of your military experience, what you learned in the military, and awards you earned.

This must be completed

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SOCIAL HISTORY
(Continued)

Family of Creation				
What is your current marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed				
If married, were any children born?			☐ Yes	☐ No
# of children:	# of daughters:	# of sons:		
Name:		Birthdate:		
Name:		Birthdate:		
Name:		Birthdate:		
Describe your relationship with each of your children:				
Have you had any other significant relationships?			☐ Yes	☐ No
How long were you in this relationship?				
Were any children born?			☐ Yes	☐ No
# of children:	# of daughters:	# of sons:		
Name:		Birthdate:		
Name:		Birthdate:		
Name:		Birthdate:		
Describe your relationship with each of your children:				

Legal		
Have you ever been convicted of a crime? (Not including minor traffic offenses) If Yes, please explain:	☐ Yes	☐ No
Are you currently on probation/parole or supervision? If Yes, please explain, include the name of your supervising officer:	☐ Yes	☐ No
Do you have any outstanding fines, warrants or pending court dates? If Yes, please explain:	☐ Yes	☐ No
Do you have any child support orders that are current or delinquent? If Yes, please explain:	☐ Yes	☐ No
Have you ever been convicted for a **Felony** charge? If Yes, please explain:	☐ Yes	☐ No

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MENTAL HEALTH HISTORY

Name:	Date:	
1. Have you ever participated in counseling in the past? If Yes, when, where, how long:	☐ Yes	☐ No
2. Are you currently in counseling?	☐ Yes	☐ No
☐ Psychiatrist ☐ Psychologist ☐ Substance Abuse Counselor ☐ Therapist/Counselor		
Counselor's Name:		
Location:		
3. Are you currently taking any psychotropic medications? If Yes, please list:	☐ Yes	☐ No
4. As an adult, have you ever felt suicidal or contemplated suicide?	☐ Yes	☐ No
5. Have you ever made an attempt to commit suicide? If Yes, please describe the circumstances:	☐ Yes	☐ No
6. Are you suicidal at this time?	☐ Yes	☐ No
7. Do you have a plan for how to kill yourself? If Yes, what is your plan:	☐ Yes	☐ No
8. Are you planning to kill yourself?	☐ Yes	☐ No
9. Can you promise that you will not try t kill or hurt yourself or anyone else while at the Prince Program?	☐ Yes	☐ No
10. Are you feeling depressed at this time to an extent that you are unable to function normally?	☐ Yes	☐ No
11. Have you recently or ever stopped eating?	☐ Yes	☐ No
12. Have you had trouble sleeping recently?	☐ Yes	☐ No
13. Do you feel anxious?	☐ Yes	☐ No
14. Do you feel unable to leave the house, to go about your normal business?	☐ Yes	☐ No
15. Do you have any other emotional problems that have not been mentioned? If Yes, please explain:	☐ Yes	☐ No
16. Have you ever had a panic/anxiety attack? When:	☐ Yes	☐ No
17. Have you ever been diagnosed with PTSD?	☐ Yes	☐ No

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MENTAL HEALTH HISTORY
(Continued)

When:		
18. Have you ever been diagnosed with depression? When?	☐ Yes	☐ No
19. Do you have nightmares?	☐ Yes	☐ No
20. Do you have a family history of mental illness? If Yes, please explain:	☐ Yes	☐ No
21. If you have psychotropic medications, do you take them as prescribed?	☐ Yes	☐ No
22. Have you ever been hospitalized for mental health reasons? If Yes, please explain:	☐ Yes	☐ No

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SUBSTANCE ABUSE PROFILE

Name:	Date:	
Read each question carefully	Check the correct response	
1. Is the use of alcohol/drugs a part of your life? Check: ☐ alcohol ☐ drugs ☐ both	☐ Yes	☐ No
2. Have you ever tried to control or stop your use?	☐ Yes	☐ No
3. Is the use of alcohol/drugs a part of your daily routine?	☐ Yes	☐ No
4. Have you ever felt guilty as a result of your drinking/drug use?	☐ Yes	☐ No
5. Have you ever used alcohol or drugs to help you sleep, relax or relieve stress?	☐ Yes	☐ No
6. Do you feel you re a normal drinker?	☐ Yes	☐ No
7. Have you ever drank or used drugs more than you planned?	☐ Yes	☐ No
8. Have you ever awakened after drinking or using drugs and found that you could not remember part of the previous 24 hours?	☐ Yes	☐ No
9. Have friends or family expressed concerns about your drinking/drug use?	☐ Yes	☐ No
10. Have you ever been arrested as a result of drinking/drug use?	☐ Yes	☐ No
11. Have you ever been in any accidents where alcohol/drugs were involved?	☐ Yes	☐ No
12. Have you ever attended an AA, NA, Al-Anon or Alateen meeting?	☐ Yes	☐ No
13. Did anyone in your family have problems with alcohol? If Yes, which family members:	☐ Yes	☐ No
14. Have you ever been concerned about a family member's drinking or drug usage? If Yes, which family members:	☐ Yes	☐ No
15. Do you find your moods changing as a direct result of your drinking/drug use?	☐ Yes	☐ No
16. Are you currently in a substance abuse treatment program? If Yes, please give the time period when involved in treatment:	☐ Yes	☐ No
17. How long have you been in recovery:		
18. Do you maintain success over substance abuse by participating in a support group?	☐ Yes	☐ No
19. Have you ever had a DUI conviction? How many? Please explain:	☐ Yes	☐ No
20. Have you ever been in jail or placed on probation because of alcohol/drugs? If Yes, please explain:	☐ Yes	☐ No

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SUBSTANCE ABUSE PROFILE
(Continued)

21. Are you currently on a waiting list for a substance abuse treatment program?	☐ Yes	☐ No
22. Can you stop drinking without a struggle in 1 or 2 drinks?	☐ Yes	☐ No
23. Do you try to limit your drinking to certain times of the day or to certain places?	☐ Yes	☐ No
24. Are you always able to stop drinking when you want to?	☐ Yes	☐ No
25. Have you gotten into fights when drinking or using drugs?	☐ Yes	☐ No
26. Have you ever lost a significant other because of alcohol/drugs?	☐ Yes	☐ No
27. Have you ever gotten into trouble at work because of alcohol/drugs?	☐ Yes	☐ No
28. Have you ever lost a job because of alcohol/drugs?	☐ Yes	☐ No
29. Have you ever neglected your family or your job for more than two days in a row because you were drinking or using drugs?	☐ Yes	☐ No
30. Do you ever drink or use drugs before noon?	☐ Yes	☐ No
31. Have you ever been told you have liver problems? ☐ Cirrhosis? ☐	☐ Yes	☐ No
32. Have you ever had Delirium Tremors (DTs), severe shaking, heard voices or seen things others cannot after drinking?	☐ Yes	☐ No
33. Have you ever gone to anyone for help about your drinking/drug use?	☐ Yes	☐ No
34. Have you ever been hospitalized because of alcohol/drugs?	☐ Yes	☐ No
35. Have you ever been a patient in a psychiatric hospital or on a psychiatric unit where alcohol/drugs were part of the problem?	☐ Yes	☐ No
36. On the average, how many days a week do you drink alcohol and/or use drugs? (1-7 days)		
37. When you drink, on the average, how many drinks do you have? (one drink = 1 beer = 1 glass wine = 1 shot of hard liquor = 1 oz of alcohol)		
38. Have you ever been treated for alcoholism?	☐ Yes	☐ No
39. How concerned are you abut your current relationship with alcohol or drugs? ☐ 1. Not concerned at all. ☐ 4. Concerned. ☐ 2. Not concerned, but I'm careful. ☐ 5. Very concerned. ☐ 3. A little concerned. ☐ 6. I want help.		
40. Have you ever participated in a detox program? ☐ Inpatient ☐ Outpatient	☐ Yes	☐ No

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SUBSTANCE ABUSE PROFILE

(Continued)

41. # of detox/rehab treatment programs: *(Check one)* ☐ none ☐ 1-3 ☐ 3-5 ☐ 5-7 ☐ more than 7		
42. Most recent detox/rehab treatment program: *(Check one)* ☐ Current ☐ 1-6 mos ☐ 6-12 mos ☐ 1-3 yrs ☐ 3-5 yrs ☐ 5-10 yrs ☐ 10+ yrs		
43. Location of most recent program:		
44. Last known date of alcohol/drug use:		
45. Drug(s) of choice: 1) 2) 3)		
46. Method of use: ☐ drinking ☐ snorting ☐ smoking ☐ intravenous		
47. Do you currently attend AA/NA meetings? # per week:	☐ Yes	☐ No
48. Have you been clean and sober for the past 30 days?	☐ Yes	☐ No
49. Do you feel that your use of alcohol and/or other drugs has impacted your ability to relate to others around you or to maintain steady housing and employment?	☐ Yes	☐ No
50. Do you feel that you have any issues with your use of alcohol and/or other drugs of abuse to the extent that you continue to use them regardless of the consequences?	☐ Yes	☐ No

State of Illinois
Department of Veterans' Affairs

CONSENT FOR RELEASE OF INFORMATION

1. I, _____, hereby give consent to:

2. IL State Police via Biometric Impressions (Provider of Information) 260 North Chicago Street Joliet, IL 60432 (Address)

3. to release information concerning _____ B.D. _____

4. to: Illinois Department of Veterans Affairs, One Veterans Drive, Manteno, IL 60950 (Address)

TYPE OF INFORMATION
(CIRCLE)

5. Medical (specify): _____

6. Mental Health (specify): _____

7. Education: _____

8. Social History/Assessment (specify): _____

9. Financial (specify): _____

10. Other (specify): IL State Police criminal background check results

11. THE PURPOSE FOR REQUESTING THIS INFORMATION IS: Criminal Background check to review for admission process for the Prince Home

I understand that I may revoke this consent at any time by notifying the Provider of Information listed in Line 2 above in writing. Revocation will be effective except to the extent that action has been taken in reliance on this consent. I also understand that, even if I do not revoke this consent, the consent will expire one year from the date provided on line 13 or line 14 below unless an earlier date is specified.

12. _____ (Signature of Applicant) _____ (Date) _____ (Date consent expires)
Address _____

13. _____ (Signature of POA, Guardian, or Authorized Agent) _____ (Date) _____ (Date consent expires)
Address _____

14. _____ (Signature of Witness) _____ (Relationship) _____ (Date)

REDISCLOSURE CONSENT: The information to be disclosed is confidential and is provided only to the party specified in the above consent. The receiving party cannot redisclose the information. I (we) hereby consent to redisclose to:

_____
(if none other, enter "none other").

_____ (Signature of Applicant) _____ (Date) _____ (Date consent expires)

_____ (Signature of POA, Guardian, or Authorized Agent) _____ (Date) _____ (Date consent expires)

See reverse side of form for instructions

INSTRUCTIONS FOR COMPLETING THE FORM

Line 1: Enter the name of the person giving consent.

Line 2: Enter the name and address of the facility or person that is the custodian of the information requested. It may be necessary to prepare a consent form for each provider if there are multiple providers with medical, mental health or substance abuse records that need to be released.

Line 3: Enter the name and date of birth of the person whose records or information will be released. Prepare a separate consent form for each person whose records are to be released.

Line 4: Enter the name and address of the agency or person to which the information will be released. Do not use specific names to avoid problems in the event of case transfers, job changes, etc. If it will be necessary to share the information beyond the named entity or person, the private agency or contractor, the Redisclosure Consent section at the bottom of the form must be completed. Without consent for redisclosure it may be necessary to prepare additional consent forms to authorize redisclosure.

Lines 5-10: Enter the specific type of information to be released. Include relevant years of treatment/services. The law prohibits blanket consents. The consent should cover all documents ***relevant*** to the purpose for which the information is requested. You do not need to know of the existence of a particular document to request it. There should be a correlation between the type of information requested and the reason(s) for the request entered on line 5.

Line 11: Enter the reason for requesting the information.

Line 12: An Applicant consenting to the release of his/her own records shall sign on Line 12. The consent will expire one year from the date signed unless an earlier date is specified.

Line 13: Enter the signature, date and address of the POA, legal guardian or Authorized Agent giving consent to the person whose information is requested.

Line 14: A witness who is familiar with the person giving consent must sign and date the consent form when mental health information is requested.

Redisclosure Consent: This section must be completed when the information will be shared with persons outside of the Department or private agency or contractor named on line 4. For information referenced in line 12 of the instructions, the same procedures must be followed for redisclosure. The redisclosure consent will expire one year from the date signed unless an earlier date is specified.