

# Housing First for Youth Intake Package

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This template was developed to accompany  
*THIS is Housing First for Youth*  
*Part 2 – Operations Manual.*



Complete in the first 30 days

Staff to Complete

Youth to Complete

# HOUSING FIRST FOR YOUTH INTAKE PACKAGE

Please advise the young person that these questions will help us to support them while they are in the program.

Please note that some of the questions may overlap with the [YAP Tool](#) or another assessment tool. In such cases, you can transfer information from one place to the next to avoid repeating questions.

Date of Intake:	Emergency Contact:  <b>Importance of this person in your life?</b>  Name:  Address:   Contact Phone Number:   Relationship:	Legal Guardian (if under 18):  <b>How often do you speak to this person?</b>  Name:  Address:   Contact Phone Number:   Relationship:
Referred by:  Reason for Referral:	HF4Y Case Counsellor:	
CAS Status: (if applicable)	CAS Worker: (if applicable)	CAS Worker #: (if applicable)

Legal First Name:
Legal Last Name:
Preferred Name:

Preferred Pronoun:
DOB and AGE (MM/DD/YEAR and AGE):
Youth Contact Info #/email(text/phone) What is the best way to reach you and what time of day works best?
Health Care #:
Social Insurance Number (SIN):
Ethnicity (how do you identify):
Indigenous: <input type="checkbox"/> Metis: <input type="checkbox"/> Inuit: <input type="checkbox"/> First Nations: <input type="checkbox"/>
Home Community:
Do you have any dependents?
Do you have any pets?

Gender (check **all** that apply)

- |   |                                     |                                      |                                      |  |
|---|-------------------------------------|--------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> boy/man          | <input type="checkbox"/> girl/woman | <input type="checkbox"/> transgender | <input type="checkbox"/> transsexual | <input type="checkbox"/> trans boy/man |
| <input type="checkbox"/> trans girl/woman | <input type="checkbox"/> two-spirit | <input type="checkbox"/> genderqueer | <input type="checkbox"/> genderfluid | <input type="checkbox"/> androgynous   |
| <input type="checkbox"/> non-binary       | <input type="checkbox"/> genderless | <input type="checkbox"/> intersex    | <input type="checkbox"/> cisgender   | <input type="checkbox"/> other_____    |

Religion/Spiritual Beliefs:	Language(s) Spoken:
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Height:	Weight:
Hair Color:	Eye Color:
Right / Lefthanded (Circle)	

Physical Characteristics (e.g. glasses, scars, birthmarks, tattoos, etc.):

## Medical Information

*(You will be able to transfer information in this section from the YAP assessment. If you didn't get the information during assessment, ask for it again.)*

Do you have any physical health concerns? Are you receiving support for them?

Do you have any mental health concerns? Are you receiving support for them?

Do you have any substance abuse or addictions issues? Are you receiving support for them?

**Support Plan:** (i.e., things that staff should be aware of, triggers, safety for youth, areas or people that upset you, things you don't like to hear)

What makes you feel better when you are upset?

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<p><b>Mental Health and Behavioral History.</b> <i>(You will have most of this information from the YAP. Transfer it to this section so that all staff are aware of the presenting and historical issues.)</i></p>

**Medication Information**

Current Medication:
Why is it being prescribed?
Date First Prescribed:
Dosage and Time:

Do you have asthma? (Circle) Yes / No
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Do you have any allergies? (Circle) Yes / No
If so, to what?

Do you have an EpiPen or need one? (Circle) Yes / No
When does it expire? _____

## Family and Natural Support Contact Information

*Family and Natural Supports: who is important in your life and closest to you, including your friends and family.*

Who do you consider your family? Who are the people closest to you and why?

Name:
Relationship:
Tel. #:
Address:
Do you have contact with them? (Circle) Yes / No
Do you want to have contact with them? (Circle) Yes / No

Name:
Relationship:
Tel. #:
Address:
Do you have contact with them? (Circle) Yes / No
Do you want to have contact with them? (Circle) Yes / No

Name:
Relationship:
Tel. #:
Address:

Do you have contact with them? (Circle) Yes / No

Do you want to have contact with them? (Circle) Yes / No

What are your family relationships like? Describe in your own words:

Do your relationships look and feel the way you want them to? Can we support you with them?

Who would you call if something cool/exciting happened to you?

Who would you call if you needed financial help or an emergency?

**Professional Contacts Information and Numbers:**

	<u>Name</u>	<u>Address</u>	<u>Telephone #</u>
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Doctor:			
Therapist:			
Optician:			
Probation Officer:			
School Contact:			
Peer Support Worker:			
Children's Aid:			
Other:			

Are there any other professionals that we can support you with or that you want to be connected to?

**School Information:**

Current School:
Grade level completed:
School Contact Person:
Phone Number:

<p><b>Do you have any involvement with the Legal System? (Circle) Yes / No</b>  <i>(If yes, please complete section below)</i></p>
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**Legal Information:**

*All information should be transferred over from the YAP.*

Current Charge/Ticket(s):	Pending Court Date(s):
Previous Charges:	Outcome: <input type="checkbox"/> Probation <input type="checkbox"/> Extrajudicial Measures <input type="checkbox"/> Incarceration <input type="checkbox"/> Community Work <input type="checkbox"/> Other
Additional Notes:	

**Complete the following information if applicable** (all information should be transferred over from the YAP):

Probation Officer's Name:
Address:
Phone:
Probation Conditions:
Community Hours Outstanding:
Are there any No Contact orders we should be aware of? Are there any places in the city that you are not allowed to be in?

Lawyer's/Legal Aid Contact:	Phone #:

**Do you have a Job?**

*All information should be transferred over from the YAP.*

Employer:
Address:
Contact Information:
Previous Employers:

**You! We Want to learn about You! If you feel comfortable to share:**

What is important to you (personal items, people, food, holidays, family traditions):

Favourite things to do in your free time:
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Favourite places to hang out:

What do you see as your STRENGTHS?

Wish or goal you have or want to do:

Have you ever lived on your own before? If so, when? (Did you have a lease? Manage and pay your own bills?)

What kind of housing do you think you would like? (Live on your own, Roommate, Basement Suite, Room for rent etc.)

Is there anything we can do to make sure you feel comfortable and supported in your new home? Any worries you have?

Is there anything that might trigger you or you think might be challenging about living on your own?

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Any other cool things we should know about you that you want to share?