Harmony House Maternity Group Home
Resident Intake Form

Referred by: _____

Person making referral: _____

Date: _____

Contact Name: _____

Contact Number: _____

Name of Youth: _____

AGE: _____

Social Security #: _____

DOB: _____

School: _____

Last Grade Completed _____

Race: _____

Shelter: _____

Shelter Address: _____

Are you currently pregnant? Yes or No

How many months is participant? _____

Last prenatal appointment: _____

Dr. Name: _____

Address: _____

Contact# _____

Next appointment: _____

Anticipated date of delivery:

Last permanent address:

Are you attending any school or Program at this time?

Do you have an open DYFS case?

Name of DYFS worker_____

Contact # _____

Office# _____

Are you receiving WIC at this time? _____

Are there any Health Problems? _____

How are you coping with your pregnancy?

_____

Are there any emotional problems in the family?

Is there any history of drug/alcohol abuse? Yes No

Family Information

Mothers Name: _____

Whereabouts: _____

Fathers Name: _____

Whereabouts: _____

How will this program help you?

Do you have problems with authority? _____

Do you have problems obeying rules and regulations? ____

How did you become homeless?

Emergency Contacts: _____

Name: _____

Address: _____

Telephone number: _____

Relationship: _____

Emergency Contacts: _____

Name: _____

Address: _____

Telephone number: _____

Relationship:_____

Case Manager's/Remarks/Observations

Case Manager Signature_____ Date_____

Coordinator's Signature_____ Date_____

New Community Harmony House
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973-623-8555
www.newcommunity.org

Applicant Interview Results: (For Staff Following Final Interview)

Applicant's Name: _____

The above applicant has been

Approved: Yes or No

Approved with the following condition:

Approved pending following:

Not approved for the following reasons:

The outcome of this interview has been reviewed and approved:

_____ _____

Coordinator: Client Services. Administrator

Date_____ Date_____

This applicant was notified on: Date _____ Move in date_____

Services needed: (check all that apply) –

( ) Child Care ( ) Mental Health Evaluation

( ) Personal Counseling ( ) Drug Screening

( ) Pregnancy Test ( ) GED

( ) Parenting Skills ( ) Career Counseling

( ) Life Skills ( ) Orientation

( ) Nutrition ( ) Basic Skills

Document Check List

Resident Name_____ Unit #_____

____ Congregate Housing ____ Clustered Housing

____ Client's Birth Certificate

____ Child's Birth Certificate

____ Client's Social Security Card

____ Child's Social Security Card