



DROP-IN CENTER INTAKE

Case Manager: _____	Intake Worker: _____
Health Counselor: _____	Age Verified: Yes <input type="checkbox"/> No <input type="checkbox"/>
Mental Health Specialist: _____	Intake Date: ____/____/____
	Intake Time: ____:____ AM PM

Welcome to the Ali Forney Center!

I understand that AFC provides a variety of services for LGBTQ homeless youth, ages 16 to 24, and that I will be offered services based on my stated needs, along with an assessment conducted by staff. These services may include any of the following: supportive counseling, meals, healthcare, shelter, and entitlement programs, mental health assessment and treatment, substance abuse assessment and treatment, STI and HIV prevention counseling and testing, and linkage to HIV treatment. By signing below, I agree that the information I have provided is true and that I agree to receive services at AFC. I understand that if I do not follow program rules, I may not be able to receive services. I may also decide to stop receiving services at any time.

Client (Print Name): _____

Date: _____

Client (Signature): _____

HOW ARE YOU FEELING TODAY?

Suicidal Hopeless A Little Sad Neutral Okay Happy Very Excited Wildly Excited

FOR STAFF USE ONLY

Checked-in by _____

Notes:

Date of check-in _____

Follow up/plan needed? _____



Rules of Conduct

1. I will not engage in a physical altercation with my fellow peers or staff members in or around the facility. I will not verbally or physically threaten my peers or Staff.
2. I will treat all Staff and my fellow peers with respect; I will not engage in name calling or bullying. I understand that this is a shade-free environment, and that I may be asked to leave if I am being shady.
3. I will not cyber-bully any of my peers, this includes text message or on any other social media website.
4. I will not engage in any sexual activity with fellow clients while in or around the facility.
5. I will not solicit sexual acts or sexually harass my peers or staff.
6. I will not steal anything from the program, staff, building or any fellow residents.
7. I will not use or sell alcohol and/or illegal drugs in or around the facility.
8. I will not be under the influence of alcohol and/or illegal drugs while inside the facility.
9. I will not smoke while inside the facility.
10. I will not carry or use a weapon while in or around the facility. If I am currently carrying a weapon, I am able to turn it in upon intake without consequence.
11. I understand that if my behavior is disruptive, I will be asked to leave.
12. I understand that sleeping is not permitted while inside the facility.
13. I understand that the front waiting area is for appointments only, any other time I should be in the group room.
14. I understand this is a program and while groups are running, I must be in a group or leave the program.
15. I understand that the Ali Forney Center is not responsible for any of my belongings and that if I leave any of my belongings here, they may be discarded.
16. I will not loiter (i.e. hang out) outside of the building or on the block. Smoke breaks or outside discussions should be taken off the block.
17. I will not compromise the confidentiality of the space by gesturing to people on the streets, banging on the windows, or yelling down the street.
18. I must be under 25 years or age to participate in services at AFC. I will provide documentation of my age within 1 week of intake.
19. I will not engage in any gang activity in or around AFC property. I understand this means no flagging, no colors, no beads, and no recruiting.



I have read and understand my responsibilities as a member of the Ali Forney Center. I understand that non-compliance with any of these responsibilities could result in a suspension from the program or that I could be asked to leave the program permanently.

Staff: _____ **Date:** _____

Client: _____ **Date:** _____

Declaration of Confidentiality

As a member of the Ali Forney Day Center, you have the right to confidentiality. This means that staff do not have the right to share any information about you verbally or in writing with anyone outside the agency without your written consent. However, in some cases, we must bring outside individuals into the relationship, without your consent, to ensure your safety and well-being and that of others.

Essentially, everything you say/do/express is confidential EXCEPT:

- Intent or plan(s) to harm yourself
- Intent or plan(s) to harm another person
- Knowledge or case(s) of a child being abused/harmed

Also, please note that information about you may be shared with co-workers and supervisors at Ali Forney Center at large only to obtain professional guidance and suggestions regarding treatment planning. Discretion will be used.

My signature below means that I have read the above confidentiality policy and that I fully understand my rights as a participant.

Staff: _____ **Date:** _____

Client: _____ **Date:** _____



Client Grievance Policy

Policy: Clients have recourse to make formal complaints about the quality of the services provided by AFC staff. Clients have the right to file grievances if they have been sexually harassed or witnessed staff misconduct.

Procedure: Clients are given notice of the Grievance Policy during the Intake Assessment. At any time thereafter, clients can bring any concerns regarding staff conduct to the attention of the Program Director by filling out a Grievance Form. If the problem is with the Program Director, they may bring their concern to the attention of the Executive Director by filling out a Grievance Form.

The Program Director and/or the Executive Director will investigate any allegations brought forth by clients and will respond to the clients as appropriate. Both the client's Grievance Form and the Director's Grievance Response are filed in the Monthly Reporting Binder.

Staff: _____

Date: _____

Client: _____

Date: _____

Thank you for coming to the Ali Forney Center. Please answer the following questions the best you can. This will give us a little background so we know how to support you. Your answers are completely confidential.

Date:

Preferred name:

Legal name:

Date of birth:

Age:

Gender pronoun:

- He/Him She/Her They/Them Ze/Zer Did not answer Other

Gender identity:

- Trans-Woman Trans-Male Cis-Woman Cis-Man Genderqueer Intersex Did not answer Other

Sexual orientation:

- Gay Lesbian Bisexual Straight Unsure, questioning Did not answer Other

What is your sex assigned at birth?

- Male Female Intersex Chose not to respond

Marital status:

- Single Married Divorced Separated Domestic Partnership Widow(er) Other

Where are you staying now?

- Temporarily with parents / guardians
 Temporarily with friends, relatives, or other people
 In a motel or hotel
 In a shelter (emergency housing, DV housing, etc.)
 In a train, park, on the street, or other public place
 In a facility (hospital, ward, jail)
 Other

Are you currently homeless or in need of housing?

- yes no

If YES, how did you become homeless, or why are you in need of housing?

If YES, how long have you been homeless?

- few weeks
 few months
 more than 6 months
 more than a year
 few years or more

Have you been homeless before?

- yes no

If YES, can you tell me more about that?

Would you like to be put on our housing waiting list?

- yes no

Are you seeking LGBTQ-specific services?

- yes no

If YES, why are you seeking LGBTQ-specific services?

If you identify as LGBTQ, please choose the responses that fit how you feel about the sentences below. This will help us design more supportive services for everyone who comes here.

I have a positive attitude about being LGBTQ.

- (1) Strongly agree (2) Agree (3) Mixed feelings (4) Disagree (5) Strongly disagree (3) Don't know

I feel uneasy around people who are very open in public about being LGBTQ.

- (5) Strongly agree (4) Agree (3) Mixed feelings (2) Disagree (1) Strongly disagree (3) Don't know

I often feel that I am ashamed that I am LGBTQ.

- (5) Strongly agree (4) Agree (3) Mixed feelings (2) Disagree (1) Strongly disagree (3) Don't know

For the most part I enjoy being LGBTQ.

- (1) Strongly agree (2) Agree (3) Mixed feelings (4) Disagree (5) Strongly disagree (3) Don't know

I worry a lot about what others think about my being LGBTQ.

(5) Strongly agree (4) Agree (3) Mixed feelings (2) Disagree (1) Strongly disagree (3) Don't know

I feel proud about being LGBTQ.

(1) Strongly agree (2) Agree (3) Mixed feelings (4) Disagree (5) Strongly disagree (3) Don't know

I wish I weren't LGBTQ.

(5) Strongly agree (4) Agree (3) Mixed feelings (2) Disagree (1) Strongly disagree (3) Don't know

What are your top 3 needs at this time?

1st identified need:

2nd identified need:

3rd identified need:

Have you received services from AFC before?

Yes No Don't remember

Have you ever stayed in one of our shelter apartments?

Yes No Don't remember

How did you hear about AFC?

Online / website Social media Friends / relatives Other agencies Other

If OTHER AGENCIES, which one?

Did you ever talk to an outreach worker about AFC?

Yes No Don't know

Have you ever interacted with an AFC representative on AFC's website?

Yes No Don't Know

Have you ever interacted with an AFC representative on Facebook?

Yes No Don't Know

Have you ever interacted with an AFC representative on a chat site?

Yes No Don't Know

Have you ever interacted with an AFC representative through twitter?

Yes No Don't Know

Have you ever received a text message from an AFC Outreach worker?

Yes No Don't Know

Contact Information

Phone number(s)

Email address(es)

Social networking site(s)

What is the best way to reach you?

Identification & Insurance

Do you have the following with you now?

Birth certificate?

yes no

Social security card?

yes no **What is your Social security number?** _____ - _____ - _____

NY State ID?

yes no

NY state benefit card?

yes no

Medicaid?

yes no

ADAP?

yes no

Other medical insurance?

yes no

If YES, what is your insurance provider?

Is this insurance under your name? If not, who is the primary planholder?

Food stamps / SNAP benefits?

yes no

Cash assistance / temporary assistance?

yes no

Any other IDs?

Background Information

Where were you born?

Manhattan Brooklyn Bronx Queens Staten Island Other

If born outside of the US, what month and year did you come to the US? (MM/YYYY)

Where did you grow up? (Where did you live the longest?)

Manhattan Brooklyn Bronx Queens Staten Island Long Island Upstate NY Out of state Overseas

If out of state, what state?

If overseas, what country?

Are you a US citizen?

Yes No Did not answer

How do you identify?

- Black / African American
- Hawaiian / Pacific Islander
- White / Caucasian
- American Indian / Alaskan
- Asian
- Mixed Race
- Not listed
- Did not answer

Are you Hispanic or Latinx / Latino?

Yes No Did not answer

If YES, what ethnic group do you consider yourself?

- Central American
- Cuban
- Dominican
- Mexican
- Puerto Rican
- South American
- Not listed

***What was the last grade of school that you completed?**

- 9th grade
- 10th grade
- 11th grade
- 12th grade
- College
- Other

***Do you have a high school diploma?**

- Yes
- No

***Do you have a GED/TASC?**

- Yes
- No

***Have you taken college classes?**

- Yes
- No

***Are you currently in school?**

- Yes
- No

If yes, where do you go to school?

***Were you ever enrolled in special education?**

- Yes
- No

***Have you ever participated in a vocational training program?**

- Yes
- No

***Did you complete a vocational training program?**

- Yes
- No

Are you currently working now?

- Full-time, regular job
- Part-time, regular job
- Occasional part-time work, odd jobs
- Not working
- Not working, looking for work
- Other

In the past 30 days, how much money did you receive from the following sources?

Wages from working

\$ _____

Non-legal income

\$ _____

Public assistance

\$ _____

Family / Friends

\$ _____

Social Security (SSI / SSDI)

\$ _____

Total income in past 30 days

\$ _____



Please take a minute to answer some questions about your Sexual Health.

ALL OF YOUR ANSWERS ARE KEPT CONFIDENTIAL.

Please answer honestly and to the best of your knowledge. Thank YOU!

Have you had sex with? (select all that apply)	In the past 5 years:	In the past 6 months:	If yes, select all that apply	Without a condom?
Ciswomen	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chose not to respond	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chose not to respond	<input type="checkbox"/> Vaginal <input type="checkbox"/> Anal <input type="checkbox"/> Oral	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cismen	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chose not to respond	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chose not to respond	<input type="checkbox"/> Vaginal <input type="checkbox"/> Anal <input type="checkbox"/> Oral	<input type="checkbox"/> Yes <input type="checkbox"/> No
Transgender Women	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chose not to respond	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chose not to respond	<input type="checkbox"/> Vaginal <input type="checkbox"/> Anal <input type="checkbox"/> Oral	<input type="checkbox"/> Yes <input type="checkbox"/> No
Transgender Men	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chose not to respond	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chose not to respond	<input type="checkbox"/> Vaginal <input type="checkbox"/> Anal <input type="checkbox"/> Oral	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gender non-conforming, non-binary, or questioning persons?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chose not to respond	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chose not to respond	<input type="checkbox"/> Vaginal <input type="checkbox"/> Anal <input type="checkbox"/> Oral	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever....

Been diagnosed with hemophilia/coagulation disorder?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chose not to respond
Received a blood product or transplant?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chose not to respond
Had a body piercing from an unlicensed piercer?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chose not to respond
Had a tattoo from an unlicensed artist?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chose not to respond
Lived with someone who had Hep C?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chose not to respond
Had chronic hemodialysis?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chose not to respond
Been exposed to blood or body fluids while at work?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chose not to respond
Snorted drugs?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chose not to respond



**THANK YOU FOR COMPLETING THE CLIENT INTAKE AT
THE ALI FORNEY CENTER!**

INTAKE DAY AND TIME

**Please let staff know what day and time you are available to complete
the intake process!**

MONDAY 9:00AM , 2:00PM & 5:00PM

TUESDAY 9:00AM & 2:00PM

WEDNESDAY 9:00AM & 5:00PM

THURSDAY 9:00AM & 2:00PM

FRIDAY 9:00AM & 2:00PM

SATURDAY 2:00PM

SUNDAY 2:00PM