eliminating racism
empowering women
ywca

YWCA Yonkers
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YWCA Health Care Workforce Advancement

Basic Information

Intake Date: _____ **ID#:** _____

Participants Name: _____
Last First Middle

Address: _____
Street Apt.#

_____
City State Zip Code

Tel/Cell#: _____ **18 & Over**: ☐ Yes ☐ No

Date of Birth: _____ **Age:** _____
Month/Day/Year

Emergency Contact Information: **Name:** _____

Relation: _____ **Tel#:** _____

Demographics

Citizen of U.S.: ☐ Yes ☐ No

Ethnicity: ☐ Multi-Race ☐ Black ☐ Latino/Hispanic ☐ White ☐ Asian
☐ Native American ☐ Other

Employment Status: ☐ F/T ☐ P/T ☐ Out of work less than 6 months
☐ Out of work 6-12 months ☐ Out of work 1 year or more ☐ No work experience

Current Student Status: ☐ F/T Student ☐ P/T Student ☐ None

If you are attending school either F/T or P/T, what school are you attending and when will you graduate or complete? _____
_____
_____
_____

Highest Educational Level: ☐ 8th Grade or less ☐ 9th - 12th Grade/Non-Graduate
☐ HS Graduate/GED ☐ Some College ☐ 2 or 4 year College Graduate

Trainings: Are you currently attending a training program? ☐ Yes ☐ No.

Have you completed any training(s) in the past? ☐ Yes ☐ No.

If you answered "**yes**" to any of the questions above please list all trainings that you are currently involved with or that you have completed and have received a certificate for;

1. **Name:** _____ **Date of Completion:** _____
   Certification: ☐ Yes ☐ No.

2. **Name:** _____ **Date of Completion:** _____
   Certification: ☐ Yes ☐ No.

Household Information

Household Type: ☐ Single ☐ Single Parent (w/ children under 18) ☐ Single Living w/Parents
☐ Single (non-custodial parent) ☐ Two Parents (no children) ☐ Two Parents (w/ children under 18)

Number of child(ren) under 18yrs. of age: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 or More

Number in Household: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or More

Housing: ☐ Own ☐ Rent ☐ Homeless/Shelter ☐ Transitional Housing
☐ SRO ☐ Foster Care/Aged out ☐ Other

Please explain your housing arrangement/situation; _____
_____
_____
_____

Choose Medical Training: ☐ Medical/Billing Coding ☐ EMT ☐ Medical Assistant
☐ Pharmacy Tech ☐ Dental Assistant ☐ X-Ray Tech ☐ Surgical Tech ☐ Medical Tech
☐ Patient Care Technician ☐ Phlebotomist ☐ Home Health Aide ☐ Sonogram Tech

Other:_____
_____
_____

Childcare Needed? ☐ Yes ☐ No
If yes, what is the age of the child(ren):_____

Physical Health: How will you best describe your physical health?

☐ Poor ☐ Good ☐ Excellent

Do you have any physical limitations or have been diagnosed with a health condition that will prevent you from working? ☐ Yes ☐ No

If yes, please describe your physical limitations (things you cannot do); _____

_____

_____

_____

Mental Health: How will you best describe your mental health?

☐ Poor ☐ Good ☐ Excellent

Do you have any mental limitations or been diagnosed with a mental challenge that will prevent you from working? ☐ Yes ☐ No

If yes, please describe your mental limitations (things you cannot do); _____

_____

_____

_____

Barrier(s): Are there any barriers (no food, transportation, housing, family court, or other issues/concerns) that you feel you need assistance with? ☐ Yes ☐ No

If yes, what are the barriers? _____

_____

_____

_____

_____

_____

I certify that the information contained in this intake form is factual to the best of my knowledge and I agree to update any information that may change.

Participant Signature: _____ Date: _____

Witness (staff) Signature: _____ Date: _____