This form was prepared by the Office of Homeless Services and is optional and not required for HMIS monitoring.

# Agency/Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Assessment Date: \_\_\_\_\_\_\_\_\_\_\_

## Section 1: Complete for All Household Members (Adults and Minors)

### CLIENT INFORMATION

Referral Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enrollment CoC: \_\_\_\_\_\_\_\_\_\_\_\_

Client Name: First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Data Quality

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ☐ Full Name Reported | ☐ Partial, Street, or Code Name Reported | | ☐ Client Doesn’t Know | ☐ Client Prefers not to Answer |
| Social Security Number \_\_\_\_\_\_\_\_ -\_\_\_\_\_ - \_\_\_\_\_\_\_\_  Social Security Number Data Quality | | |
| ☐ Full SSN Reported | | ☐ Approximate or Partial SSN Reported | ☐ Client Doesn’t Know | ☐ Client Prefers Not to Answer |

|  |  |  |  |
| --- | --- | --- | --- |
| Veteran Status | |  |  |
| ☐ Yes | ☐ No | ☐ Client Doesn’t Know | ☐ Client Prefers Not to Answer |

Relationship to Head of Household

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ☐ Self | | ☐ Head of household’s spouse or partner | | ☐ Other: non-relation member | |
| ☐ Head of household’s child | | ☐ Head of household’s other relation member | |
| Date of Birth \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_    Date of Birth Data Quality | | | |
| ☐ Full DOB Reported | ☐ Approximate or Partial DOB Reported | | ☐ Client Doesn’t Know | | ☐ Client Prefers Not to Answer |

Gender (select as many as apply)

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Woman (Girl, if child) | ☐ Culturally specific Identity (e.g., Two-Spirit) | ☐ Non-Binary | ☐ Questioning |
| ☐ Man (Boy, if child) | ☐ Different Identity | ☐ Transgender |
| ☐ Client Doesn’t Know | ☐ Client prefers not to answer | ☐ Data Not Collected | If Different Identity Please Specify: |

Race & Ethnicity

|  |  |
| --- | --- |
| ☐ American Indian, Alaska Native, or Indigenous | ☐ White |
| ☐ Asian or Asian American | ☐ Client Doesn’t Know |
| ☐ Black, African American, or African | ☐ Client Prefers Not to Answer |
| ☐ Hispanic/Latina/e/o | ☐ Data not collected |
| ☐ Middle Eastern or North African | Additional Info: |
| ☐ Native Hawaiian or Pacific Islander |  |

Translation Assistance Needed (Only Complete for HoH)

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Yes | ☐ No | ☐ Client Doesn’t Know | ☐ Client prefers not to answer |

If yes, preferred language

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Spanish | ☐ Arabic | ☐ Kurdish | ☐ Somali |
| ☐ American Sign Language | ☐ Other: |  |  |

### DISABILITY INFORMATION

Does the client have a Disabling Condition?

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Yes | ☐ No | ☐ Client Doesn’t Know | ☐ Client Prefers Not to Answer |

If yes, check all that apply

|  |  |  |
| --- | --- | --- |
| ☐ Alcohol abuse | ☐ HIV/AIDS | ☐ Substance Use Disorder |
| ☐ Chronic health condition | ☐ Mental Health Disorder |  |
| ☐ Developmental | ☐ Physical |

### HEALTH INSURANCE INFORMATION

Is the client covered by Health Insurance?

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Yes | ☐ No | ☐ Client Doesn’t Know | ☐ Client Prefers not to Answer |

If yes, check all that apply

|  |  |
| --- | --- |
| ☐ \_\_\_\_\_\_\_\_ Medicaid | ☐ \_\_\_\_\_\_\_\_ COBRA |
| ☐ \_\_\_\_\_\_\_\_ Medicare | ☐ \_\_\_\_\_\_\_\_ Private Pay Health Insurance |
| ☐ \_\_\_\_\_\_\_\_ State Children’s Health Insurance | ☐ \_\_\_\_\_\_\_\_ State Health Insurance for Adults |
| ☐ \_\_\_\_\_\_\_\_ VA Heath Administration (VHA) | ☐ \_\_\_\_\_\_\_\_ Indian Health Services Program |
| ☐ \_\_\_\_\_\_\_\_ Employer-Provided Health Insurance | ☐ \_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

## Section 2: Complete for Head of Household and All Adults

Is client pregnant?

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Yes | ☐ No | ☐ Client Doesn’t Know | ☐ Client Prefers not to Answer |

If yes, does client know their approximate birth date? \_\_\_\_\_\_\_\_ If yes, projected birth date: \_\_\_\_\_\_\_\_\_

Sexual Orientation

|  |  |
| --- | --- |
| ☐ Heterosexual | ☐ Client Doesn’t Know |
| ☐ Gay | ☐ Client Prefers Not to Answer |
| ☐ Lesbian | ☐ Data not collected |
| ☐ Bisexual | If Other Please Describe: |
| ☐ Questioning/Unsure |  |
| ☐ Other |  |

HOMELESS HISTORY QUESTIONS

Living Situation (Check where the client stayed last night):

|  |  |  |
| --- | --- | --- |
| **HOMELESS SITUATION** |  | **TEMPORARY HOUSING SITUATION** |
| ☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/aiport or anywhere outside) |  | ☐ Transitional housing for homeless persons (including homeless youth) |
| ☐ Emergency shelter, including hotel/motel paid for with an emergency shelter voucher, Host Home shelter |  | ☐ Residential project or halfway house with no homeless criteria |
| ☐ Safe Haven (this is a type of emergency shelter bed - not Safe Haven Family Shelter) |  | ☐ Hotel or motel paid for without emergency shelter voucher |
| **INSTITUTIONAL SITUATION** |  | ☐ Host Home (non-crisis) |
| ☐ Jail, prison, or juvenile detention facility |  | ☐ Staying or living in a friend's room, apartment, or house |
| ☐ Long-term care facility or nursing home |  | ☐ Staying or living in a family member's room, apartment, or house |
| ☐ Substance abuse treatment or detox center |  | **PERMANENT HOUSING SITUATION** |
| ☐ Foster care home or foster care group home |  | ☐ Rental by client, no ongoing housing subsidy |
| ☐ Psychiatric Hospital or other psychiatric facility |  | ☐ Rental by client, with ongoing housing subsidy |
| ☐ Hospital or other residential non-psychiatric medical facility |  | ☐ Owned by client, with ongoing housing subsidy |
| **OTHER** |  | ☐ Owned by client, no ongoing housing subsidy |
| ☐ Other |  |  |
| ☐ Worker unable to determine |  |  |
| ☐ Client doesn’t know |  |  |
| ☐ Client Prefers not to Answer |  |  |
| ☐ Data not collected |  |  |

*SUBSIDY- IF PERMANENT HOUSING*

|  |  |  |
| --- | --- | --- |
| ☐ GPD TIP Housing Subsidy | ☐ Public housing unit | ☐ Foster Youth to Independence Initiative  (FYI) |
| ☐ VASH Housing Subsidy | ☐ Rental by client with other ongoing housing subsidy | ☐ Permanent Supportive Housing |
| ☐ RRH or equivalent subsidy | ☐ Emergency Housing Voucher | ☐ Other permanent housing dedicated for formerly homeless persons |
| ☐ HCV voucher (tenant or project based) (not dedicated) | ☐ Family Unification Program Voucher (FUP) |

How long did the client stay there (the place they stayed last night)?

|  |  |  |
| --- | --- | --- |
| ☐ One night or less | ☐ One week or more, but less than one month | ☐ 90 days or more, but less than one year |
| ☐ Two to six nights | ☐ One month or more, but less than 90 days | ☐ One year or longer |

**What is the approximate start date of this episode of homelessness? \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_**

Regardless of where they stayed last night, total # of times (episodes) the client has been on the streets or in an emergency shelter in the past 3 years including today:

|  |  |  |
| --- | --- | --- |
| ☐ One time | ☐ Three times | ☐ Client doesn’t know |
| ☐ Two times | ☐ Four or more times | ☐ Client prefers not to answer |

Total # of months the client has been on the street or in an emergency shelter in the past 3 years (round up):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ☐ 1 (this is the 1st month) | ☐ 4 months total | ☐ 7 months total | ☐ 10 months total | ☐ More than 12 months |
| ☐ 2 months total | ☐ 5 months total | ☐ 8 months total | ☐ 11 months total | ☐ Client doesn’t know |
| ☐ 3 months total | ☐ 6 months total | ☐ 9 months total | ☐ 12 months total | ☐ Client prefers not to answer |

### INCOME INFORMATION

Record each adult’s income on their own intake form. If a minor child has income, include it on the HoH’s intake.

Does the client have Income from any source?

Total Monthly Income: $\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Yes | ☐ No | ☐ Client Doesn’t Know | ☐ Client Prefers not to Answer |

If yes, check all that apply and include amount per month:

|  |  |
| --- | --- |
| $\_\_\_\_\_\_\_\_ Alimony or other spousal support | $\_\_\_\_\_\_\_\_ SSI |
| $\_\_\_\_\_\_\_\_ Child support | $\_\_\_\_\_\_\_\_ SSDI |
| $\_\_\_\_\_\_\_\_ Earned income | $\_\_\_\_\_\_\_\_ TANF |
| $\_\_\_\_\_\_\_\_ General Assistance | $\_\_\_\_\_\_\_\_ Unemployment Insurance |
| $ \_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | $\_\_\_\_\_\_\_\_ VA non-service connected disability pension |
| $\_\_\_\_\_\_\_\_ Pension or retirement income | $\_\_\_\_\_\_\_\_ VA service connected disability compensation |
| $\_\_\_\_\_\_\_\_ Private disability insurance | $\_\_\_\_\_\_\_\_ Worker’s Compensation |
| $\_\_\_\_\_\_\_\_ Retirement income from social security |  |

### NON-CASH BENEFIT INFORMATION

Does the client have Non-Cash Benefits from any source?

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Yes | ☐ No | ☐ Client Doesn’t Know | ☐ Client prefers not to answer |

If yes, check all that apply and include amount per month:

|  |  |  |
| --- | --- | --- |
| $\_\_\_\_\_\_\_\_ SNAP | $\_\_\_\_\_\_\_\_ TANF Child Care Services | $\_\_\_\_\_\_\_\_ Other TANF-Funded Services |
| $\_\_\_\_\_\_\_\_ WIC | $\_\_\_\_\_\_\_\_ TANF Transportation Services | $\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

### DOMESTIC VIOLENCE INFORMATION

Is Client a Survivor of Domestic Violence?

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Yes | ☐ No | ☐ Client Doesn’t Know | ☐ Client Prefers not to answer |

If yes, when did experience occur?

|  |  |  |
| --- | --- | --- |
| ☐ Within the past 3 months | ☐ 6 to 12 months ago | ☐ Client doesn’t know |
| ☐ 3 to 6 months ago | ☐ More than a year ago | ☐ Client prefers not to answer |

If yes, is the client currently fleeing domestic violence?

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Yes | ☐ No | ☐ Client Doesn’t Know | ☐ Client prefers not to answer |

### GENERAL HEALTH STATUS

What is the client’s general health status?

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Excellent | ☐ Good | ☐ Poor | ☐ Client Prefers not to Answer |
| ☐ Very Good | ☐ Fair | ☐ Client Doesn’t Know |  |

## Section 3: Complete for Head of Household Only

HOUSING MOVE-IN DATE

What date did the Head of Household move into permanent housing? \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_

*Please complete one form for each household member at Entry.*