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 | ☐ American Sign Language (ASL) |
| ☐ Somali | ☐ 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 |
| ☐ \_\_\_\_\_\_\_\_ Veteran’s Health 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOMELESS HISTORY QUESTIONS

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

HOMELESS SITUATIONS

|  |  |  |
| --- | --- | --- |
| ☐ Place not meant for habitation  (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) | ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home shelter | ☐ Safe Haven |

INSTUTIONAL SITUATIONS

|  |  |  |
| --- | --- | --- |
| ☐ Foster care home or foster care group home | ☐ Hospital or other residential non-psychiatric medical facility | ☐ Jail, prison, or juvenile detention facility |
| ☐ Long-term care facility or nursing home | ☐ Psychiatric hospital or other psychiatric facility | ☐ Substance abuse treatment facility or detox center |

TEMPORARY HOUSING SITUATIONS

|  |  |  |
| --- | --- | --- |
| ☐ Transitional housing for homeless persons (including homeless youth) | ☐ Residential Project or halfway house with no homeless criteria | ☐ Hotel or motel paid for without emergency shelter voucher |
| ☐ Host Home (non-crisis) | ☐ Staying or living in a friend's room, apartment, or house | ☐ Staying or living in a family member's room, apartment, or house |

PERMANENT HOUSING SITUATIONS

|  |  |  |
| --- | --- | --- |
| ☐ Rental by client, no ongoing housing subsid | ☐ Rental by client, with ongoing housing subsidy | ☐ Owned by client, with ongoing housing subsidy |
| ☐ Owned by client, on ongoing housing subsidy |

*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) |

OTHER

|  |  |  |
| --- | --- | --- |
| ☐ Client doesn’t know | ☐ Client Prefers not to Answer | ☐ Data Not Collected |

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?

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

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

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 |

Section 3: Complete for all Household Members with HIV/AIDS

MEDICAL ASSISTANCE

Receiving AIDS Drug Assistance Program (ADAP)

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

If no, reason

|  |  |  |
| --- | --- | --- |
| ☐ Applied; decision pending | ☐ Client did not apply | ☐ Client doesn’t know |
| ☐ Applied, client not eligible | ☐ Insurance type N/A for this client | ☐ Client prefers not to answer |

Receiving Ryan-White funded Medical or Dental Assistance

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

If no, reason

|  |  |  |
| --- | --- | --- |
| ☐ Applied; decision pending | ☐ Client did not apply | ☐ Client doesn’t know |
| ☐ Applied, client not eligible | ☐ Insurance type N/A for this client | ☐ Client prefers not to answer |

# T-CELL (CD4) AND VIRAL LOAD

T-Cell (CD4) Count Available

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

If yes, T-Cell Count: \_\_\_\_\_\_\_\_\_\_

How was the information obtained?

|  |  |  |
| --- | --- | --- |
| ☐ Medical Report | ☐ Client Report | ☐ Other |

Viral Load Information Available

|  |  |  |
| --- | --- | --- |
| ☐ Not available | ☐ Undetectable | ☐ Client prefers not to answer |
| ☐ Available | ☐ Client doesn’t know |  |

Viral Load Count: \_\_\_\_\_\_\_\_\_\_

How was the information obtained?

|  |  |  |
| --- | --- | --- |
| ☐ Medical Report | ☐ Client Report | ☐ Other |

# PRESCRIBED ANTI-RETROVIRAL

Has the participant been prescribed anti-retroviral drugs?

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Yes | ☐ No | ☐ Client Doesn’t Know | ☐ Client Refused |

Section 4: Complete for Head of Household Only

Housing Move-in Date (enter at Entry): \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_

*Note: Grantees must also enter HOPWA Services Provided and Financial Assistance Provided in HMIS.*

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