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

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

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

Social Security Number \_\_\_\_\_\_\_\_ -\_\_\_\_\_ - \_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_

## 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 |

Connection with SOAR?

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

### 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 |

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 |

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 prefers not to answer |

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