

MSHMIS VASH Intake Assessment

Project Start Date: _____

Intake Staff/Case Manager: _____

HOUSEHOLD INFORMATION (UDE)					
Answer this section for all persons in household (use additional sheets for larger families)					
Full Name	Relationship to Head of Household	SSN	US Military Veteran	Date of Birth mm/dd/yyyy	Gender
<p><u>Name Data Quality</u></p> <input type="checkbox"/> Full name <input type="checkbox"/> Partial, street or code name <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input checked="" type="checkbox"/> Self (Head of household) <p>Client Location (CoC Code):</p> <p>_____</p> <p style="text-align: center;"><i>Required for Head of Household Only</i></p>	<p>_____</p> <p><u>SSN Data Quality</u></p> <input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Approximate or partial SSN reported <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<p>(Answer for adults 18+ only)</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<p style="text-align: center;">/ /</p> <p><u>DOB Data Quality</u></p> <input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate or partial DOB <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans Female (M to F) <input type="checkbox"/> Trans Male (F to M) <input type="checkbox"/> Gender Non-Conforming (not exclusively M or F) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
<p><u>Name Data Quality</u></p> <input type="checkbox"/> Full name <input type="checkbox"/> Partial, street or code name <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Head of Household's child <input type="checkbox"/> Head of household's spouse or partner <input type="checkbox"/> Head of household's other relation member (other relation to head of household) <input type="checkbox"/> Other: non-relation member	<p>_____</p> <p><u>SSN Data Quality</u></p> <input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Approximate or partial SSN reported <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<p>(Answer for adults 18+ only)</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<p style="text-align: center;">/ /</p> <p><u>DOB Data Quality</u></p> <input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate or partial DOB <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans Female (M to F) <input type="checkbox"/> Trans Male (F to M) <input type="checkbox"/> Gender Non-Conforming (not exclusively M or F) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
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HOUSEHOLD INFORMATION (UDE) continued...

If client has a disabling condition, please answer the following sub-assessment questions:

Name <i>(Please Answer for Each Person in Household)</i>	Race <i>(Select all that apply)</i>	Ethnicity	Does the client have a disabling condition?	Disability Type <i>(Select all that apply)</i>	<i>If Yes, to be long-continued and indefinite duration and substantially impairs ability to live independently?</i>
Person 1 (head of household):	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Non- Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problem <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
Person 2:	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Non- Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problem <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
Person 3:	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Non- Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problem <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
Person 4:	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Non- Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problem <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused

HOUSEHOLD INFORMATON (Program Specific) continued...

Name <i>(Answer for All Persons in Household)</i>	Currently Covered by Health Insurance?	<i>(If Client has Health Insurance)</i> Select All Type(s) That Apply
Person 1 (head of household):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran Administration (VA) Medical Services <input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Other (Please Specify: _____)
Person 2:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran Administration (VA) Medical Services <input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Other (Please Specify: _____)
Person 3:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran Administration (VA) Medical Services <input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Other (Please Specify: _____)
Person 4:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran Administration (VA) Medical Services <input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Other (Please Specify: _____)

Housing Status

Answer the following questions for ALL Household Members

- Category 1 – Homeless
 Category 2 – At imminent risk of losing housing
 Category 3 – Homeless only under other federal statutes
 Category 4 – Fleeing domestic violence
 At-risk of homelessness
 Stably Housed
 Client doesn't know
 Client refused

RESIDENCE

City of Residence _____ County of Residence _____

Living Situation (UDE) - Homeless History Interview

****Answer for HEAD OF HOUSEHOLD and ADULTS (18+) only****
(Use additional sheets if ADULT members of the same household have different homeless histories)

Chronic status is determined by a client's history of homelessness, disability status, and the length of time spent on the street, in an emergency shelter or safe haven. Requires a substantiated disability and, continuously homeless for past 12 months to qualify or 4 separate occasions in the past 3 years as long as the combined occasions total at least 12 months. Intake workers should not instruct the client on the length of time/# of episodes necessary to qualify as chronically homeless. Questions should be asked in the exact order they are presented below.

Describe the client's living situation (immediately) prior to project entry?

(Select one Living Situation and answer the corresponding questions in the order in which they appear)

	Literally Homeless Situation	Institutional Situation	Transitional/Permanent Housing Situation	Don't Know/ Refused
SECTION I	<input type="checkbox"/> Place not meant for habitation (e.g. a vehicle, abandoned building, bus/train/subway station, airport, anywhere outside). <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher. <input type="checkbox"/> Safe Haven <input type="checkbox"/> Interim Housing (e.g. client applied for permanent housing and a unit/voucher has been reserved but client is not able to move in immediately).	<input type="checkbox"/> Foster care home or foster group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons (such as CoC Project) <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with VASH subsidy <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy (including RRH) <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused

****Answer the following questions for HEAD OF HOUSEHOLD and ADULTS only! (Print additional pages where needed) ****

DOMESTIC VIOLENCE

Domestic Violence Victim/Survivor should be indicated as "Yes" if the person has experienced any domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has taken place **within the individual's or family's primary nighttime residence.**

Domestic Violence Victim/Survivor? Yes No Client doesn't know Client refused

(If yes) When Experience Occurred

Within the past three months Three to six months ago (excluding six months exactly) Six months to one year ago (excluding one year exactly)
 One year ago or more Client doesn't know Client refused

Currently fleeing should be indicated as "Yes" if the Person is fleeing, or is attempting to flee, the domestic violence situation **or** is afraid to return to their primary nighttime residence.

(If yes) Are you currently fleeing? Yes No Client doesn't know Client refused

Overview of domestic violence: _____

VETERAN INFORMATION for HEAD OF HOUSEHOLD and ADULTS (18+) only!

Date Entered Military Service _____ Date Separated from Military Service _____

Theatre of Operations: World War II Korean War Vietnam War Persian Gulf War-Desert Storm Afghanistan-Enduring Freedom
 Iraq-Freedom Iraq-New Dawn Other Peacekeeping Operations/Military Interventions (Lebanon, Panama, Somalia, Bosnia, Kosovo)
 Client Doesn't Know Client Refused

Branch of the Military: Army Air Force Navy Marines Coast Guard Client Doesn't Know Client Refused

Discharge Status: Honorable General under honorable conditions Under other than honorable conditions Bad Conduct Dishonorable
 Uncharacterized Client Doesn't Know Client Refused

VAMC Station Number

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CONTACT INFORMATION

Client's Cell Phone Number: _____

Emergency Contact's Name: _____

Contact Type (Relationship to Client): _____

Phone Number: _____

Second Phone Number: _____

Contact's E-mail Address: _____

Contact's Street Address: _____

Contact's City: _____ State: _____ Zip Code: _____

Emergency Contact's Name: _____

Contact Type (Relationship to Client): _____

Phone Number: _____

Second Phone Number: _____

Contact's E-mail Address: _____

Contact's Street Address: _____

Contact's City: _____ State: _____ Zip Code: _____

