

NC HMIS SSVF 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 style="text-align: center; margin-top: 10px;"><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
<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
<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

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 INFORMATION (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 AND SERVICE

City of Residence _____ County of **Residence** _____ County of **Service** _____

Living Situation (UDE) - Homeless History Interview

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

SECTION II	Literally Homeless Situation	Institutional Situation	Transitional/Permanent Housing Situation	Don't Know/Refused
	Length of Stay in Prior Living Situation (i.e. the literally homeless situation identified above)? <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer	Length of Stay in Prior Living Situation (i.e. the institutional situation identified above)? <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than one year Did you stay in the institutional situation less than 90 days? <input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO- End Homeless History Interview)	Length of Stay in Prior Living Situation (i.e. the housing situation identified above) <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than one year Did you stay in the housing situation less than 7 nights? <input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO – End Homeless History Interview)	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
SECTION III	N/A Complete SECTION IV Below	On the <u>night before</u> entering the institutional situation did you stay on the streets, in emergency shelter or a safe haven? <input type="checkbox"/> Yes (If YES – Complete SECTION IV) <input type="checkbox"/> No (If NO- End Homeless History Interview)	On the <u>night before</u> entering the housing situation did you stay on the streets, in emergency shelter or a safe haven? <input type="checkbox"/> Yes (If YES – Complete SECTION IV) <input type="checkbox"/> No (If NO – End Homeless History Interview)	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused

Have the client look back to the date of the last time s/he) "had a place to sleep **other than** the streets, ES, or SH".
 If the client knows the month and year but not the day, the worker may substitute the day of the month with the same day of the month as project entry.

What Counts as a Break in Homelessness?
 As the client looks back, there may be breaks in their stay on the streets, ES, or SH. A break in homelessness is considered to be:

- 7 or more consecutive nights in a Housing Situation (see Section III above).
- 90 or more consecutive days in an Institutional Situation (see Section II above)

Follow-up questions:
 1. "Did you stay anywhere other than on the streets, in emergency shelter, or safe haven for less than 7 nights" (if not an institution). or
 2. "Were you in jail/hospital/other Institution less 90 days" (if break is an institution).

If 1 or 2 is yes, include all those days in the client's total number of days homeless and continue back to the next break in homelessness.

SECTION IV	Approximate date homelessness started: _____ (M/D/YYYY)	
	Regardless of where they stayed last night -- Number of <u>times</u> the client has been on the streets, in ES, or SH in the <u>past three years, including today</u> <input type="checkbox"/> One Time <input type="checkbox"/> Two Times <input type="checkbox"/> Three Times <input type="checkbox"/> Four or more Times	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
	Total number of <u>months</u> homeless (on the street, in emergency shelter or safe haven) in the <u>past 3 years?</u> (e.g. # of cumulative, but not necessarily consecutive months spent homeless) <input type="checkbox"/> One month (this time is the first month) <input type="checkbox"/> 2 – 12 months → Must specify # months _____ <input type="checkbox"/> More than 12 months	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused

ADULT CARE HOME for HEAD OF HOUSEHOLD and ADULTS (18+) only!

Has Client Lived in an Adult Care Home in 2012? No Yes Client doesn't know Client refused

(If Yes) Adult Care Home Client Lived In Most Recently: _____

INCOME & NON-CASH BENEFITS

**** Answer for HEAD OF HOUSEHOLD and ADULTS (18+) only****

Currently receiving income from any source? Yes No Client doesn't know Client refused

X	Source of Income (Monthly)	Family Member	Amount from Source
	Alimony or Other Spousal Support		\$.00
	Child Support		\$.00
	Earned Income (<i>Employment</i>)		\$.00
	General Assistance		\$.00
	Pension or Retirement Income from a Former Job		\$.00
	Private Disability Insurance		\$.00
	Retirement Income from Social Security		\$.00
	SSDI (<i>Social Security Disability Insurance</i>)		\$.00
	SSI (<i>Supplemental Security Income</i>)		\$.00
	TANF (<i>Temporary Assistance for Needy Families or FIP grant</i>)		\$.00
	Unemployment Insurance		\$.00
	VA Service-Connected Disability Compensation		\$.00
	VA Non-Service-Connected Disability Pension		\$.00
	Workers Compensation		\$.00
	Other (<i>Including Gifts from Friends and Family</i>) Specify: _____		\$.00
	No Financial Resources		N/A

Total Monthly Income \$ _____ (Per Household Member)

Percentage of AMI: Less than 30% 30% to 50% Greater than 50%

Currently receiving any non-cash benefits? Yes No

Client doesn't know Client refused

X	Source of Non-Cash Benefit (Monthly)	Family Member	Amount (If applicable)
	Supplemental Nutrition Assistance Program (SNAP) (<i>previous known as Food Stamps</i>)		\$.00
	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)		\$.00
	TANF Child Care Services		\$.00
	TANF Transportation Services		\$.00
	Other TANF Funded Services		\$.00
	Other Source – Specify: _____		\$.00

LAST PERMANENT ADDRESS for HEAD OF HOUSEHOLD and ADULTS (18+) only!

Client's Address: _____ City: _____ State: _____ Zip Code: _____

Last Permanent Address Data Quality: Full Address Reported Incomplete or Estimated Address Reported Client doesn't know Client refused

LAST GRADE COMPLETED
for HEAD OF HOUSEHOLD and ADULTS (18+) only

Highest Level of Education Attained: Less than Grade 5 Grades 5-6 Grades 7-8 Grades 9-11 Grade 12/High school diploma GED
 Some College School program does not have grade levels Associate's Degree Bachelor's Degree Graduate Degree Vocational Certification
 Client doesn't know Client refused

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, Somalia, Panama, 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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CONNECTION WITH SOAR

Yes No Client Doesn't Know Client Refused

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:** _____

HOUSING MOVE-IN DATE
for RAPID REHOUSING only!

Answer for the Head of Household

*This question differentiates between clients who are awaiting placement and those who have moved into any type of permanent housing, regardless of funding source or whether the project is providing rental assistance. The Housing Move-In Date MUST be entered via an **Interim Assessment** with a timestamp that occurs after the Project Start and before the Project Exit. If client is **not** in housing leave this question blank.*

Housing Move-In Date: ____/____/____

HP TARGETING CRITERIA
for PREVENTION only!

Answer for Head of Household

Referred by Coordinated Entry or a homeless assistance provider to prevent the household from entering an emergency shelter or transitional housing or from staying in a place not meant for human habitation. Yes No

Current housing loss expected within... 0-6 days 7-13 days 14-21 days More than 21 days

Current household income is \$0 (i.e., not employed, not receiving cash benefits, no other current income) Yes No

Annual Household Gross Income Amount (for household size) 0-14% of Area Median Income (AMI) 15-30% of AMI More than 30% of AMI

Sudden and significant decrease in cash income (employment and/or cash benefits) AND/OR unavoidable increase in non-discretionary expenses (e.g., rent or medical expenses) in the past 6 months. Yes No

Major change in household composition (e.g., death of family member, separation/divorce of adult partner, birth of new child) in the past 12 months Yes No

Rental evictions within the past 7 years 4 or more prior rental evictions 2-3 prior rental evictions 1 prior rental eviction None

Currently at risk of losing a tenant-based housing subsidy or housing in a subsidized building or unit Yes No

History of Literal Homelessness (street/shelter/transitional housing) 4 or more times or total of at least 12 months in past three years 2-3 times in past three years 1 time in past three years None

Head of household with disabling condition (physical health, mental health, substance use) that directly affects ability to secure/maintain housing Yes No

Criminal record for arson, drug dealing or manufacture, or felony offense against persons or property. Yes No

Registered sex offender Yes No At least one dependent child under age 6 Yes No Single parent with minor child(ren) Yes No

Household size of 5 or more requiring at least 3 bedrooms (due to age/gender mix) . Yes No

Any Veteran in household served in Iraq or Afghanistan. Yes No Female Veteran. Yes No