

Identifying Information

\*Last Name: \_\_\_\_\_ \*DOB: \_\_\_\_\_ \*Status Date: \_\_\_\_\_

\*First Name: \_\_\_\_\_ \*SSN (last 4 digits): \_\_\_\_\_ \*Project: \_\_\_\_\_

Disabling Conditions*Long Term defined: expected to be of long-continued and indefinite duration and impairs their ability to live independently*

Physical Disability:     Yes\*\*                       Client doesn't know                      \*\*If yes, long term?     Yes  
                                           No                                       Client prefers not to answer                       No

Developmental Disability     Yes                                       Client doesn't know  
                                           No                                       Client prefers not to answer

Chronic Health Condition     Yes\*\*                                       Client doesn't know                      \*\*If yes, long term?     Yes  
                                           No                                       Client prefers not to answer                       No

HIV - AIDS                                       Yes                                       Client doesn't know  
                                           No                                       Client prefers not to answer

Mental Health Disorder     Yes\*\*                                       Client doesn't know                      \*\*If yes, long term?     Yes  
                                           No                                       Client prefers not to answer                       No

Substance Use Disorder                                       Client doesn't know                      \*\*If yes, long term?     Yes  
      Alcohol use\*\*     Both \*\*                                       Client prefers not to answer                       No  
      Drug use\*\*         Neither

Domestic Violence Survivor     Yes\*\*                                       Client prefers not to answer                      \*\*When DV experience occurred:  
                                           No                                       Client doesn't know                       Less than 3 months

Currently Fleeing DV                                       Yes\*\*                                       Client prefers not to answer                       3 months - less than 6 months  
                                           No                                       Client doesn't know                       6 months - less than a year  
                                           No                                       Client doesn't know                       1 year or more  
                                           No                                       Client prefers not to answer                       Client doesn't know  
                                           No                                       Client prefers not to answer                       Client prefers not to answer

## HUD Financial Assessment

- Income From Any Source?     Yes\*\*     Client doesn't know  
 No     Client prefers not to answer

\*\*If yes, select all that apply, and enter the amount earned per MONTH.

- |                                                                                   |                                                                              |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| <input type="checkbox"/> \$_____ Unemployment                                     | <input type="checkbox"/> \$_____ TANF                                        |
| <input type="checkbox"/> \$_____ Earned Income (employment)                       | <input type="checkbox"/> \$_____ General Assistance                          |
| <input type="checkbox"/> \$_____ SSI <input type="checkbox"/> \$_____ SSDI        | <input type="checkbox"/> \$_____ Retirement Income from Social Security      |
| <input type="checkbox"/> \$_____ VA Service Connected Disability Compensation     | <input type="checkbox"/> \$_____ Pension/Retirement from a former job        |
| <input type="checkbox"/> \$_____ VA non-service Connected Disability Compensation | <input type="checkbox"/> \$_____ Child Support                               |
| <input type="checkbox"/> \$_____ Private Disability Insurance                     | <input type="checkbox"/> \$_____ Alimony/Spousal support                     |
| <input type="checkbox"/> \$_____ Worker's Compensation                            | <input type="checkbox"/> \$_____ Other income source, specify below<br>_____ |

Receiving Non-Cash Benefits?

If yes, select all that apply:

- |                                                                                   |                                         |                                                                 |
|-----------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Yes** <input type="checkbox"/> Client doesn't know       | <input type="checkbox"/> SNAP           | <input type="checkbox"/> TANF Transportation                    |
| <input type="checkbox"/> No <input type="checkbox"/> Client prefers not to answer | <input type="checkbox"/> WIC            | <input type="checkbox"/> Other TANF Services                    |
|                                                                                   | <input type="checkbox"/> TANF Childcare | <input type="checkbox"/> Other non-cash benefit source<br>_____ |

- Covered by Health Insurance?     Yes\*\*     Client doesn't know  
 No       Client prefers not to answer

\*\*If yes, select all that apply:

- |                                                                         |                                                                  |
|-------------------------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> MEDICAID                                       | <input type="checkbox"/> Health Insurance Obtained Through COBRA |
| <input type="checkbox"/> MEDICARE                                       | <input type="checkbox"/> Private Pay Health Insurance            |
| <input type="checkbox"/> State Children's Health Insurance Program      | <input type="checkbox"/> State Health Insurance for Adults       |
| <input type="checkbox"/> Veteran's Administration (VA) Medical Services | <input type="checkbox"/> Indian Health Services Program          |
| <input type="checkbox"/> Employer-Provided Health Insurance             | <input type="checkbox"/> Other Health Insurance<br>_____         |

- \*Pregnancy Status     Yes --Due Date \_\_\_\_\_  
(Required for street outreach)     No  
 Client doesn't know  
 Client prefers not to answer

# Current Living Situation *(required for street outreach programs)*

\*Location details: \_\_\_\_\_

Homeless Situation: *If a selection is made from this area, SKIP to the end*

- |                                                                                                                                    |                                                       |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or Host Home Shelter | <u>Other:</u>                                         |
| <input type="checkbox"/> Place not meant for habitation                                                                            | <input type="checkbox"/> Client doesn't know          |
| <input type="checkbox"/> Safe Haven                                                                                                | <input type="checkbox"/> Client prefers not to answer |
|                                                                                                                                    | <input type="checkbox"/> Worker unable to determine   |

## Institutional Situation:

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

## Transitional Housing Situation

- 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 Situation

- Rental by client, **no** ongoing housing subsidy
- Rental by client, **with** ongoing housing subsidy, please specify type-->\*\*
- Owned by client, **no** ongoing housing subsidy
- Owned by client, **with** ongoing housing subsidy

## \*\*Rental Subsidy Type:

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

Is client going to have to leave their current living situation within 14 days?

- Yes  No  Client doesn't know  Client prefers not to answer

*If yes, answer remaining questions. If no, skip to end*

Has a subsequent residence been identified?

- Yes  No  Client doesn't know  Client prefers not to answer

Does individual or family have resources or support networks to obtain other permanent housing?

- Yes  No  Client doesn't know  Client prefers not to answer

Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?

- Yes  No  Client doesn't know  Client prefers not to answer

Has the client moved 2 or more times in the last 60 days?

- Yes  No  Client doesn't know  Client prefers not to answer