

Identifying Information

*SSN: _____

- Full SSN reported
- Client doesn't know
- Approximate or partial SSN
- Client prefers not to answer

*Birthdate: _____

- Full DOB reported
- Client doesn't know
- Approximate or partial DOB
- Client prefers not to answer

*LastName: _____

*FirstName: _____

- Full name reported
- Partial, street name, or code name reported
- Client doesn't know
- Client prefers not to answer

Middle name: _____

Nickname/Alias: _____

- Jr. II VI
- Sr. III Client doesn't know
- I IV Client prefers not to answer

Preferred Pronouns

- She / Her Other _____
- He / Him
- They / Them Client doesn't know
- Ze / Hir Client prefers not to answer

*Current Gender Identity

- Woman/Girl
- Man/Boy
- Culturally Specific Identity (e.g., Two-Spirit)
- Different Identity**
- Non-Binary
- Transgender
- Questioning
- Client doesn't know
- Client prefers not to answer

*Case Worker: _____

*Sex assigned at birth

- Male Client doesn't know
- Female Client prefers not to answer

★NOT required if client is a minor and NOT head of household

*★Are you intersex?

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

*★ Sexual Orientation

- Heterosexual (Straight)
- Gay Client doesn't know
- Lesbian Client prefers not to answer
- Bisexual
- Questioning/Unsure
- Other _____

Citizenship Status:

- US Citizen
- Eligible Non-Citizen
- Non-US Citizen COFA**
- US National – Non Citizen (American Samoa or Swains Island)
- Ineligible Non-Citizen
- Client doesn't know
- Client prefers not to answer

**COFA Countries:

- Chuuk-Micronesia
- Kosrae-Micronesia
- Marshall Islands
- Palau
- Pohnpei-Micronesian
- Yap-Micronesia
- Client doesn't know
- Client prefers not to answer

*Primary Language:

- Chinese
- Chuukese
- English
- Ilocano
- Japanese
- Korean
- Marshallese
- Tagalog
- Vietnamese
- Different Language _____
- Client doesn't know
- Client prefers not to answer

*Translation Assistance Needed?

- Yes**
- No
- **If yes, specify translation language needed:

*Race and Ethnicity *Select all that apply*

- American Indian, Alaska Native, or Indigenous
- Asian or Asian American, specify below**
- Black, African American, or African
- Native Hawaiian or Pacific Islander, specify below**
- White
- Hispanic/Latina/e/o/x
- Middle Eastern or North African
- Client doesn't know
- Client prefers not to answer

**Native Hawaiian / Pacific Islander

- Guamanian/Chamorro
- Micronesian
- Marshallese
- Native Hawaiian

**Asian:

- Asian Indian
- Filipino
- Chinese/Taiwanese
- Japanese

Veteran Status: Yes** No

If yes, answer questions below: If no, skip all military questions

**Year entered: _____

**Year separated: _____

**Branch of U. S. Military

- Army
- Coast Guard
- Air Force
- Space Force
- Navy
- Client doesn't know
- Marines
- Client prefers not to answer

**Discharge Status

- Honorable
- Under honorable conditions
- Under other than honorable conditions (OTH)
- Bad Conduct
- Dishonorable
- Uncharacterized
- Client doesn't know
- Client prefers not to answer

*Theater of Operations:

- World War II
- Korean War
- Vietnam War
- Persian Gulf War
- Afghanistan
- Iraq (Iraqi Freedom)
- Iraq (New Dawn)
- Other Operations
- Client doesn't know
- Client prefers not to answer

- Native Hawaiian
- Tongan
- Samoan
- Other Pacific Islander

- Korean
- Other Asian
- Vietnamese

Additional race/ethnicity detail? _____

*Consent to share?

- Yes
- No

*Consent Documentation

- Electronic Signature
- Attached PDF
- Signed Paper Document
- Verbal Consent
- Outside Agency Verified
- Household
- Group Member

*Relationship to head of household

*Date of Consent

HUD Universal

*Prior Living Situation

Project Start Date: _____

Homeless Situation: *If a selection is made from this area, fill in just Section A below.*

- Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or Host Home Shelter
- Place not meant for habitation
- Safe Haven

Institutional Situation: *If a selection is made from this area, fill in just Section B below.*

- 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: *If a selection is made from this area, fill in just Section C below.*

- 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: *If a selection is made from this area, fill in just Section C below.*

- Rental by client, *no* ongoing housing subsidy
- Rental by client, *with* ongoing housing subsidy**
- Owned by client, *no* ongoing housing subsidy
- Owned by client, *with* ongoing housing subsidy

Rental Subsidy Type

- GPD TIP housing subsidy
- VASH 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

Section A: Homeless Situation

*Length of stay in prior living situation.

- One night or less
- Two to six nights
- One week or more, but less than one month
- One month or more, but less than 90 days
- 90 days or more, but less than one year
- One year or longer
- Client doesn't know
- Client prefers not to answer

*Approximate date this episode of homelessness started: _____

Regardless of where they stayed last night) Number of times the client has been on the streets, in ES, or SH in the past three years including today.

- Never in 3 years
- One time
- Two times
- Three times
- Four or more times
- Client doesn't know
- Client prefers not to answer

*Total number of months homeless on the streets, in Emergency Shelter, of Safe Haven in the past three years.

- One month (this is the first time)
- More than one month, less than twelve

How many months? _____

- More than twelve months
- Client doesn't know
- Client prefers not to answer

Section B: Institutional Situation

*Length of stay in prior living situation.

- | | | |
|--|---|---|
| <input type="checkbox"/> One night or less | <input type="checkbox"/> One month or more, but less than 90 days | <input type="checkbox"/> One year or longer |
| <input type="checkbox"/> Two to six nights | <input type="checkbox"/> 90 days or more, but less than one year | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> One week or more, but less than one month | | <input type="checkbox"/> Client prefers not to answer |

On the night before, did you stay on the streets, Emergency Shelter, or Safe Haven?

- Yes No *If yes, continue. If no, go to Disabling Conditions and Barriers*

*Approximate date this episode of homelessness started: _____

Regardless of where they stayed last night) Number of times the client has been on the streets, in ES, or SH in the past three years including today.

- | | |
|---|---|
| <input type="checkbox"/> Never in 3 years | <input type="checkbox"/> Four or more times |
| <input type="checkbox"/> One time | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Two times | <input type="checkbox"/> Client prefers not to answer |
| <input type="checkbox"/> Three times | |

*Total number of months homeless on the streets, in Emergency Shelter, or Safe Haven in the past three years.

- One month (this is the first time)
 More than one month, less than twelve

How many months? _____

- More than twelve months
 Client doesn't know Client prefers not to answer

Section C: Transitional or Permanent Housing Situation

*Length of stay in prior living situation.

- | | | |
|--|---|---|
| <input type="checkbox"/> One night or less | <input type="checkbox"/> One month or more, but less than 90 days | <input type="checkbox"/> One year or longer |
| <input type="checkbox"/> Two to six nights | <input type="checkbox"/> 90 days or more, but less than one year | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> One week or more, but less than one month | | <input type="checkbox"/> Client prefers not to answer |

*Did you stay less than seven nights?

- Yes No *If yes, continue. If no, go to Disabling Conditions and Barriers*

*On the night before, did you stay on the streets, Emergency Shelter, or Safe Haven?

- Yes No *If yes, continue. If no, go to Disabling Conditions and Barriers*

*Approximate date this episode of homelessness started: _____

Regardless of where they stayed last night) Number of times the client has been on the streets, in ES, or SH in the past three years including today.

- | | |
|---|---|
| <input type="checkbox"/> Never in 3 years | <input type="checkbox"/> Four or more times |
| <input type="checkbox"/> One time | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Two times | <input type="checkbox"/> Client prefers not to answer |
| <input type="checkbox"/> Three times | |

*Total number of months homeless on the streets, in Emergency Shelter, or Safe Haven in the past three years.

- One month (this is the first time)
 More than one month, less than twelve

How many months? _____

- More than twelve months
 Client doesn't know Client prefers not to answer

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
 Client prefers not to answer 1 year or more
 Client doesn't know
 Client prefers not to answer

HUD Financial Assessment

Income From Any Source? Yes** No Client doesn't know 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 Comp. | <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_____ |

Receiving Non-Cash Benefits?

If yes, select all that apply:

- Yes**
- Client doesn't know
- No
- Client prefers not to answer
- SNAP
- WIC
- TANF Childcare
- TANF Transportation
- Other TANF Services
- Other non-cash benefit source

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

**If yes, select all that apply:

- MEDICAID
- MEDICARE
- State Children's Health Insurance Program
- Veteran's Administration (VA) Medical Services
- Employer-Provided Health Insurance
- Health Insurance Obtained Through COBRA
- Private Pay Health Insurance
- State Health Insurance for Adults
- Indian Health Services Program
- Other Health Insurance

Hawai'i Specific Questions

Did you arrive in Hawai'i during the past 12 months?

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

**If yes, how long have you been in Hawai'i?

Years _____ Months _____ Days _____

- Client doesn't know
- Client prefers not to answer

How many years TOTAL have you lived in Hawai'i

Before your 18th birthday, were you placed in an out-of-home placement and/or did you experience homelessness?

Select all that apply

- Foster home
- Group home
- Juvenile home
- Houseless

Marital Status

- Single Never Married
- Divorced
- Married
- Separated/Trial Separation/Partner Left
- Illness
- Widowed/Death
- Living with Partner/New Live-In Partner
- Other
- Client doesn't know
- Client prefers not to answer

Criminal Justice Status

- Parole
- Probation
- Supervised Released
- Formerly in system, completed requirements
- Drug court
- None
- Client doesn't know
- Client prefers not to answer

If the client's residence just prior to project entry was an ES, TH, or PSH project, please specify which one

Zip Code of last address _____

- Full or partial reported
- Client doesn't know
- Client prefers not to answer

How were you referred to the agency doing your intake?

- Homeless services agency**
- Self
- Hospital
- VA
- Criminal Justice System
- Aloha United Way
- Other*
- Client doesn't know
- Client prefers not to answer

Please specify:

**Homeless services agency _____

*Other source of referral _____

If Veteran: Did Veteran enter Service-Intensive Transitional Housing (SITH) for a Clinical need?

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

**If yes, describe clinical need _____

How many times in the past 12 months have you used the following emergency or medical services:

Hospital emergency room services _____

Other hospital services (medical or psychiatric) _____

911/ ambulance emergency services _____

Access (Crisis) Hotline _____

**Other emergency services _____

**Name of other emergency services _____