



HUD CoC and ESG All Project Types Intake Assessment for Children and Youth Under 18

This form is to be used in assisting case managers, intake workers, and HMIS users to record client-level program specific data elements for input into ServicePoint and follows the ServicePoint workflow for ease of input. All information on this assessment is required to be completed and entered into ServicePoint within 3 days of client intake for Emergency Shelters and Transitional Housing, and 7 days for Permanent Housing projects. A client-signed Consent to Share determining the information to be shared within HMIS **must** accompany this assessment prior to data entry.

Project: _____ **Date:** _____

Client Name: _____ **Bed (ES&TH):** _____

SSN: _____	SSN Data Quality:	<input type="checkbox"/> Full SSN reported	<input type="checkbox"/> Client doesn't know
		<input type="checkbox"/> Approximate or partial SSN reported	<input type="checkbox"/> Client refused
			<input type="checkbox"/> Data not collected

Date of Birth: _____	Date of Birth Type:	<input type="checkbox"/> Full DOB reported	<input type="checkbox"/> Client doesn't know
		<input type="checkbox"/> Approximate or partial DOB reported	<input type="checkbox"/> Client refused

Primary Race:	<input type="checkbox"/> American Indian or Alaska Native	Secondary Race (Optional):	<input type="checkbox"/> American Indian or Alaska Native
	<input type="checkbox"/> Asian		<input type="checkbox"/> Asian
	<input type="checkbox"/> Black or African American		<input type="checkbox"/> Black or African American
	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
	<input type="checkbox"/> White		<input type="checkbox"/> White
	<input type="checkbox"/> Client doesn't know		<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Client refused		<input type="checkbox"/> Client refused
<input type="checkbox"/> Data not collected	<input type="checkbox"/> Data not collected		

Ethnicity: Hispanic/Latino Client doesn't know Client refused Data not collected
 Non-Hispanic/Non-Latino

Gender:	<input type="checkbox"/> Female	<input type="checkbox"/> Transgender male to female	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Male	<input type="checkbox"/> Gender Non-Conforming	<input type="checkbox"/> Client refused
	<input type="checkbox"/> Transgender female to male		<input type="checkbox"/> Data not collected

Zip Code of Last Permanent Address (Where client most recently spent >= 90 days) _____



CONSENT TO SHARE CONFIDENTIAL INFORMATION

Client Name: _____	Start Date: _____
	End Date: _____

I request and authorize: _____ at
Staff Person(s)

Agency Name: _____

Project Name: _____

to disclose confidential information to HMIS-ERIE, the homeless database that supports the Erie, PA Continuum of Care PA-605, administered by Erie County Department of Human Services at:

HMIS Administrator
Erie County Department of Human Services MH/ID
154 West 9th Street
Erie, PA 16501

This request and authorization applies to:

- Client demographics and program entry/exit information
- Program-specific information for services and referrals only, and/or: _____

- Yes No I expressly release the above-named staff person(s) and Agency from all liability arising from compliance with this request and disclosure of the requested information to HMIS-ERIE.
- Yes No I understand my rights regarding personally identifying information as explained by the above-named staff person(s) and outlined in the HMIS-ERIE Consumer Privacy Policy.
- Yes No I authorize the release of my information, such as personal demographics, income, health, and disabilities (including drug, alcohol, and/or mental health diagnosis) to be shared with other HMIS-ERIE providers to determine program eligibility, send referrals and coordinate services.
- Yes No I authorize my demographics information only to be shared with other HMIS-ERIE providers to determine program eligibility and to maintain data integrity within HMIS-ERIE.

Client Signature: _____ Date Signed: _____

Staff Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES ONE (1) YEAR AFTER IT IS SIGNED.



Child or Youth Under Age 18 Project Entry

- Relationship to Head of Household: Self (head of household), Head of household's child, Head of household's spouse or partner, Head of household's other relation member, Other: non-relation member, Data not collected

- Residence Prior to Project Entry: Homeless Situation (Place not meant for habitation, Emergency shelter, Safe Haven, Interim Housing), Institutional Situation (Foster care home, Hospital, Jail, Long-term care facility, Psychiatric hospital, Substance abuse treatment facility), Transitional and Permanent Housing Situation (Hotel or motel, Owned by client, Permanent housing, Rental by client, Transitional housing, Client doesn't know, Client refused, Data not collected)

NOTE: The questions you will see on the Assessment screen will vary depending on the client's answer to this question and Length of Stay. If any of these questions do not appear, skip them for data entry.

- Length of Stay: 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 refused, Data not collected

- IF Client is coming from Streets, ES, or SH (Homeless Situation): Approximate Date 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: Total number of months homeless on the street, in ES or SH in the past three years: One time, Two times, Three times, Four times or more, Client doesn't know, Client refused, Data not collected, One month (this is the first time), 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, More than 12 months, Client doesn't know, Client refused, Data not collected

NOTE: Income and Non-cash benefits received for a minor (e.g. SSI) should be recorded as part of the household under the Head of Household, unless the child is an unaccompanied youth.

Total Monthly Income: \$ _____

- Income from Any Source: Yes, No, Client doesn't know, Client refused, Data not collected



Erie City and County Continuum of Care (CoC) Homeless Management Information System (HMIS)

Source of Income: \$ ____ Alimony or other spousal support \$ ____ Supplemental Security Income (SSI)
 \$ ____ Child support \$ ____ Temporary Assistance for Needy Families (TANF)
 \$ ____ Earned Income \$ ____ Unemployment Insurance
 \$ ____ General Assistance \$ ____ VA non-service-connected disability pension
 \$ ____ Other: _____ \$ ____ VA service-connected disability compensation
 \$ ____ Pension or retirement from a former job \$ ____ Retirement income from Social Security
 \$ ____ Private disability insurance \$ ____ Social Security Disability Income (SSDI) \$ ____ Worker's compensation

Non-Cash Benefit from Any Source: Yes Client doesn't know Data not collected
 No Client refused

Source of Non-Cash Benefit: \$ ____ Supplemental Nutrition Assistance Program (SNAP)
 \$ ____ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
 \$ ____ TANF child care services
 \$ ____ TANF transportation services
 \$ ____ Other TANF-funded services
 \$ ____ Section 8, public housing, or other ongoing rental assistance
 \$ ____ Other: _____
 \$ ____ Temporary rental assistance

Covered by Health Insurance: Yes No Client doesn't know Client refused Data not collected

Health Insurance Type: MEDICAID Health Insurance obtained through COBRA
 MEDICARE State Health Insurance for Adults
 State's Children Health Insurance Program Private Pay Health Insurance
 Veteran's Administration (VA) Medical Services Indian Health Insurance
 Employer-Provided Health Insurance Other: _____



Does the client have a disabling condition? Yes No Client doesn't know Client refused Data not collected

Disability Sub Assessment

If 'Yes' to question: Does client have a disabling condition, check all that apply: Alcohol Abuse Both alcohol and drug abuse Chronic Health Condition Developmental Drug Abuse HIV/AIDs Mental Health Problem Physical

If Yes, above condition is expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? Yes No Client doesn't know Data not collected Client refused

If yes, documentation of the disability and severity on file: Yes No

If yes, Currently receiving services or treatment: Yes Client doesn't know Data not collected No Client refused

Note on Disability: _____

Above condition is going to be long term? Yes No

Educational Summary – Complete for all persons

Highest Level of Education Attained: Nursery School to 4th Grade 5th Grade or 6th Grade 7th Grade or 8th Grade 9th Grade 10th Grade 11th Grade 12th Grade, No Diploma High School Diploma GED Post-secondary school No Schooling Completed Client doesn't know Client refused Data not collected

Complete for all persons 21 years of age and younger

Presently attending school? Yes No

If Yes, Name of School _____

If No, Date Last Enrolled in School ____/____/____