



HUD CoC and ESG SO, ES, SH Project Types Intake Assessment for Adults 18 and Over

This form is to be used in assisting HMIS users of Street Outreach, Emergency Shelter, and Safe Haven projects to record client-level program-specific data elements for input into ServicePoint. This form follows the ServicePoint workflow for ease of input. All information on this assessment is required to be completed and entered in ServicePoint within 2 days of collection. A client-signed Consent to Share determining the information to be shared within HMIS **must** accompany this assessment prior to data entry.

Agency/Project Name: _____ **Start Date:** _____

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

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:

<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected
<input type="checkbox"/> Non-Hispanic/Non-Latino			

Gender:

<input type="checkbox"/> Female	<input type="checkbox"/> Trans male to female	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Male	<input type="checkbox"/> Gender Non-Conforming (i.e., not exclusively male or female)	<input type="checkbox"/> Client refused
<input type="checkbox"/> Trans female to male		<input type="checkbox"/> Data not collected

U.S. Military Veteran? Yes No Client doesn't know Client refused Data not collected

Zip Code of Last Permanent Address (Where client spent >= 90 days, had mail in his/her name, etc.) _____



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.



Project Entry

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

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 SITUATIONS
 Place not meant for habitation
 Emergency shelter, including hotel or motel paid for with emergency shelter voucher
 Safe Haven
 Interim Housing (for PH placement of CH only)

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

TRANSITIONAL & PERMANENT HOUSING SITUATIONS
 Hotel or motel paid for without emergency shelter voucher
 Owned by client, no ongoing housing subsidy
 Owned by client, with ongoing housing subsidy
 Permanent housing (other than RRH) for formerly homeless persons
 Rental by client, no ongoing housing subsidy
 Rental by client, with VASH subsidy
 Rental by client, with GPD TIP subsidy
 Rental by client, with other ongoing housing subsidy (including RRH)
 Residential project or halfway house with no homeless criteria
 Staying or living in a family member's room, apartment or house
 Staying or living in a friend's room, apartment or house
 Transitional housing for homeless persons (including homeless youth)

OTHER SITUATIONS
 Client doesn't know Client refused Data not collected

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

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:
 One time Two times Three times
 Four times or more Client doesn't know Client refused
 Data not collected

Total NUMBER of MONTHS homeless on the street, in ES or SH in the past three years:
 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



Total Monthly Income: \$ _____

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

Source of Income: \$ _____ Alimony or other spousal support \$ _____ Supplemental Security Income (SSI)
 \$ _____ Child support \$ _____ TANF
 \$ _____ Earned Income \$ _____ Unemployment Insurance
 \$ _____ General Assistance \$ _____ VA Non-Service Connected Disability Pension
 \$ _____ Other: _____ \$ _____ VA Service Connected Disability Pension
 \$ _____ Pension or retirement from a former job \$ _____ Worker's compensation
 \$ _____ Private disability insurance
 \$ _____ Retirement income from Social Security
 \$ _____ Social Security Disability Income (SSDI)

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
 \$ _____ Other Source: _____ (Specify source)

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

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 Services Program
 Employer-Provided Health Insurance Other: _____

Disability Sub- Assessment
If 'Yes' to question: Does client have a disabling condition, check all that apply:

Condition	If Yes, condition is expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?				
<input type="radio"/> Alcohol Abuse	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Client doesn't know	<input type="radio"/> Client refused	<input type="radio"/> Data not collected
<input type="radio"/> Both alcohol and drug abuse	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Client doesn't know	<input type="radio"/> Client refused	<input type="radio"/> Data not collected
<input type="radio"/> Chronic Health Condition	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Client doesn't know	<input type="radio"/> Client refused	<input type="radio"/> Data not collected
<input type="radio"/> Developmental	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Client doesn't know	<input type="radio"/> Client refused	<input type="radio"/> Data not collected
<input type="radio"/> Drug Abuse	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Client doesn't know	<input type="radio"/> Client refused	<input type="radio"/> Data not collected
<input type="radio"/> HIV/AIDs	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Client doesn't know	<input type="radio"/> Client refused	<input type="radio"/> Data not collected
<input type="radio"/> Mental Health Problem	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Client doesn't know	<input type="radio"/> Client refused	<input type="radio"/> Data not collected
<input type="radio"/> Physical	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Client doesn't know	<input type="radio"/> Client refused	<input type="radio"/> Data not collected



Domestic Violence Victim/Survivor: Yes No Client doesn't know Client refused Data not collected

• **If Yes, when experience occurred:** Within the past three months From six months to one year Client doesn't know
 Three to six months ago More than a year ago Client refused
 Data not collected

• **If Yes, are you currently fleeing?** Yes No Client doesn't know Client refused Data not collected

Sub Assessment for PATH and Outreach Contacts Only

Start Date of Contact: _____ **End Date of Contact:** _____

Are you staying on the Streets, ES, or SH? Yes No Worker unable to determine

(Date of Engagement is the date on which an interactive client relationship results in a deliberate client assessment)

Date of Engagement: _____ **Housing Move-In Date:** _____

Education Summary – Complete for all School Age Children and Adults

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