HALS COC FUNDED HOUSING PROGRAM INTAKE AND ASSESSMENT FORM

Date of Application: _____

Client Demographics: please note that bolded questions are required to be answered:

First Name: _____ MI: ___ **Last Name**: _____ Suffix: ____
Name Data Quality (all clients) ☐Full name ☐Partial, street name or code name reported ☐Client doesn't know ☐Client refused
Social Security #: _____ - ____-_____ **Date of Birth**: ____/____/_____
☐Full SSN reported ☐Full date of birth reported
☐Approx. or partial SSN reported ☐Approx. or partial date of birth reported
☐Client doesn't know ☐Client doesn't know
☐Client refused ☐Client refused
Veteran Status (all adults) ☐No ☐Yes ☐Client doesn't know ☐Client refused

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Primary & Secondary Race: (use P or S)
☐ American Indian/Alaska Native
☐ Asian
☐Black/African American
☐Native Hawaiian/Other Pacific Islander
☐White
☐Client doesn't know ☐Client refused

Ethnicity (Check One):
☐Hispanic/Latino
☐Non-Hispanic/Non-Latino
☐Client doesn't know
☐Client refused

Gender (Check One):
☐Male
☐Female
☐Transgender Male to Female
☐Transgendered Female to Male
☐Other _____ ☐Client doesn't know ☐Client refused

Does the client have a disabling condition? (Check One): ☐Yes ☐No

Residence Prior to Project Entry (Head of household and adults) (Check One):

☐Emergency Shelter & motel paid by others
☐Foster Care Home or group home
☐ Hospital (non-psychiatric)
☐Hotel/Motel (w/o emergency shelter voucher)
☐Jail, prison or juvenile detention fac.
☐Long Term care facility/nursing home
☐Owned by Client, no ongoing subsidy
☐ Owned by Client, with ongoing subsidy
☐Permanent housing (CoC project)
☐ Place not meant for Habitation
☐Psychiatric hospital or other Psyc. Fac.
☐ Rental by client, no ongoing subsidy
☐Rental by client w/ VASH subsidy
☐ Rental by client,w /GPD TIP subsidy
☐Rental by client,w/other ongoing housing subsidy
☐ Residential /halfway house w/no homeless criteria
☐ Safe Haven
☐ Staying or living in family's room, apt. or house
☐ Staying or living in friend's room, apt. or house
☐ Substances abuse treatment facility or detox center
☐ Transitional homeless housing (incl. unacc. youth)
☐ Other (Describe) _____
☐ Client doesn't know
☐Client refused ☐

Length of Stay in Previous Place (head of household and adults):
☐One day or less
☐Two day to one week
☐More than one week, but less than 1 month
☐One to three months, but less than 1 year
☐One year or longer
☐Client doesn't know
☐Client Refused

Relationship to Head of Household (all clients)

- Self (head of household)
- Head of Household Child
- Head of Household's spouse or partner
- Head of Household's other relative member (other relation to head of household)
- Other – non-relation member

Client Location (Head of Household) HUD assigned CoC Code - select MD-513

NEW QUESTIONS BELOW THAT REPLACE PREVIOUS QUESTIONS ON CHRONIC HOMELESSNESS

Length of Time on Street, in an Emergency shelter (ES), or Safe Haven (SH) (head of household and adults)
Client entering from Streets, ES or SH: No Yes Client doesn't know Client refused
If yes, for Client Entering from Streets, ES or SH, Approx. date started: _____

Regardless of where they stayed last night - # of times client has been on streets, ES or SH in past 3 years, including today: 0 1 2 3 4 5 6 7 8 9 10 11 12 More than 12 Client doesn't know Client refused

Total Number of Months homeless on the street, in ES or SH in the past 3 years? _____
Status Documented: No Yes

Total Monthly Income _____
Income And Sources (head of households and adults): No Yes Client doesn't know Client refused
Income**:** Source of Income (Check All that Apply) and list amounts for each :

- Alimony/Spousal Support _____
- Child support _____
- Earned income from job _____
- General Assistance (GA) _____
- Other specify source & amount _____
- Pension/Retirement from Former Job _____
- Private Disability Insurance _____
- Retirement Income from Social Security _____
- SSDI_____
- SSI _____
- TANF/TCA/TDAP_____
- Unemployment Insurance
- VA Non-Service Conn. Diab.Pension_____
- VA Service Conn Disab. Penson_____
- Workers Compensation _____

Non Cash benefits (head of household and adults): No Yes Client doesn't know Client refused
Non Cash Benefits (Check Yes on HMIS to all that apply. Answer No for benefits that have been terminated, even if they were received in the past). Amount of Non Cash Benefits $_____

- SNAP - Food Stamps
- Special Supplemental Nutritional Program for WIC
- TANF Child Care Services
- TANF Transportation Services
- Other TANF-Funded Services
- Section 8 Public Housing or Rental Assist.
- Temporary Rental Assistance, specify ____
- Other Source: _____

Health Insurance (all clients) – Covered by health Insurance**:** No Yes Client doesn't know Client refused
Health Insurance Benefits: (Check Yes on HMIS to all that apply. Answer No for benefits that have been terminated, even if they were received in the past).

- Medicaid
- Medicare
- State Children's Health Insurance Programs
- VA Medical Services
- Employer-Provided Health Insurance
- Health Insurance obtained through COBRA
- Private Pay Health Insurance
- State Health Insurance for Adults

Disability Type (Check All that Apply):

Alcohol Abuse No Yes Client doesn't know Client refused
If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently
No Yes Client doesn't know Client refused
If Yes – Documentation of Disability and severity on file No Yes

Both Alcohol & Drug Abuse No Yes Client doesn't know Client refused
If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently
No Yes Client doesn't know Client refused
If Yes – Documentation of Disability and severity on file No Yes

Chronic Health Condition No Yes Client doesn't know Client refused
If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently
No Yes Client doesn't know Client refused

If Yes – Currently receiving services/treatment for this condition: □No □Yes □Client doesn't know □Client refused

□**Developmental** □No □Yes □Client doesn't know □Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

□No □Yes □Client doesn't know □Client refused

If Yes – Documentation of Disability and severity on file □No □Yes

If Yes – Currently receiving services/treatment for this condition: □No □Yes □Client doesn't know □Client refused

□**Drug Abuse** □No □Yes □Client doesn't know □Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

□No □Yes □Client doesn't know □Client refused

If Yes – Documentation of Disability and severity on file □No □Yes

If Yes – Currently receiving services/treatment for this condition: □No □Yes □Client doesn't know □Client refused

□**HIV/AIDS** □No □Yes □Client doesn't know □Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

□No □Yes □Client doesn't know □Client refused

If Yes – Documentation of Disability and severity on file □No □Yes

If Yes – Currently receiving services/treatment for this condition: □No □Yes □Client doesn't know □Client refused

□**Mental Health Problem** □No□Yes □Client doesn't know □Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

□No □Yes □Client doesn't know □Client refused

If Yes – Documentation of Disability and severity on file □No □Yes

If Yes – Currently receiving services/treatment for this condition: □No □Yes □Client doesn't know □Client refused

□**Physical** □No □Yes □Client doesn't know □Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

□No □Yes □Client doesn't know □Client refused

If Yes – Documentation of Disability and severity on file □No □Yes

If Yes – Currently receiving services/treatment for this condition: □No □Yes □Client doesn't know □Client refused

Is Client Domestic Violence Victim/Survivor? (Head of household and adults) □No □Yes □Client doesn't know □Client refused

If yes, when did the experience occur?

□Within 3 months □One year ago or more

□3-6 months □Client Doesn't Know

□6 -12 months □Client refused

If yes for domestic violence victim/survivor, are you currently fleeing?

□No □Yes □Client doesn't know □Client refused □ Data not collected

Household Information (children & spouse/significant others)

1.Name:_____ DOB:_____ SS#:_____

Gender: _____ Race:_____ Relationship to Applicant:_____

2.Name:_____ DOB:_____ SS#:_____

Gender: _____ Race:_____ Relationship to Applicant:_____

3.Name:_____ DOB:_____ SS#:_____

Gender:_____ Race:_____ Relationship to Applicant:_____

4.Name:_____ DOB:_____ SS#:_____

Gender:_____ Race:_____ Relationship to Applicant:_____

For any adults living in the household, complete the following:

Income And Sources (head of households and adults) : □No □Yes □Client doesn't know □Client refused

Income**:** Source of Income (Check All that Apply) and list amounts for each:

□Alimony/Spousal Support _____ □SSDI_____

□Child support ___ _____ □SSI _____

□Earned income from job _____ □TANF/TCA/TDAP_____

□General Assistance (GA) _____ □Unemployment Insurance

□Other specify source & amount _____

□Pension/Retirement from Former Job _____ □VA Non-Service Connected Diab. Pension_____
□Private Disability Insurance _____ □VA Service Connected Disab. Pension_____
□Retirement Income from Social Security □Workers Compensation _____

Non Cash benefits (head of household and adults): □No □Yes □Client doesn't know □Client refused

Non Cash Benefits (Check Yes on HMIS to all that apply. Answer No for benefits that have been terminated, even if they were received in the past). Amount of Non Cash Benefits $_____

□SNAP - Food Stamps □Other TANF-Funded Services
□Special Supplemental Nutritional Program for WIC□ □Section 8 Public Housing or Rental Assist.
□TANF Child Care Services □Temporary Rental Assistance, specify _____
□TANF Transportation Services □Other Source: _____

Health Insurance (all clients) – Covered by health Insurance**:** □No □Yes □Client doesn't know □Client refused

Health Insurance Benefits: (Check Yes on HMIS to all that apply. Answer No for benefits that have been terminated, even if they were received in the past).

□Medicaid □Employer-Provided Health Insurance
□Medicare □Health Insurance obtained through COBRA
□State Children's Health Insurance Programs □Private Pay Health Insurance
□VA Medical Services □State Health Insurance for Adults

Disability □No □Yes □Client doesn't know □Client refused If adult, list disability type_____

Is Client Domestic Violence Victim/Survivor? (Head of household and adults) □No □Yes □Client doesn't know □Client refused If yes, are you currently fleeing? □No □Yes

If yes, when did the experience occur? □Within 3 months □3-6 months □6 -12 months□ □One year ago or more □Client refused □Client doesn't know

Mental Health:

Are you currently in treatment for mental health? ☐ Yes ☐ No
Treatment Start Date:_____ Treatment End Date: _____

If yes, list diagnosis. _____
Where are you currently being treated? _____

Have you ever been hospitalized for mental health issues? ☐ Yes ☐ No
If yes, please list location and date.

Location	***Treatment Start Date***	***Treatment End Date***

Are you currently on medication? ☐ Yes ☐ No Do you take them as prescribed? ☐ Yes ☐ No

Please list any current medications:	***Dosage***	***Frequency***
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. . _____	_____	_____

Medical History:

Current Medical Issues: _____

Name of Primary Care Provider: _____

Address:_____ Phone: _____

Please list any current medications:	***Dosage***	***Frequency***
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Substance Abuse:

Do you have a substance abuse history? ☐ Yes ☐ No

If yes, list drug(s) of choice: _____

How long were you actively engaged in substance abuse? _____ Months _____ Years

Substance Abuse Treatment History: ***(List Dates & Locations)***
Treatment Start Date: Treatment End Date:

	Location	***Date***	***Location***	***Date***
A.A.				
N.A.				
Detox				
Inpatient				
Outpatient				

Has the applicant(s) ever been arrested for drug possession or distribution? ☐ Yes ☐ No

If yes, when? _____

Legal Information:

Are you on Probation? ☐ Yes ☐ No If yes, Probation Officer's Name:_____

Are you on Parole? ☐ Yes ☐ No If yes, Parole Officer's Name: _____

Current Warrant Issued? ☐ Yes ☐ No

Arrest Record:

Arrest Charge: _____Were you convicted? ☐ Yes ☐ No

Arrest Date:_____ Did you serve time? ☐ Yes ☐ No

If yes, Prison or Jail? ☐ Jail ☐ Prison

Arrest Charge:_____ Were you convicted? ☐ Yes ☐ No

Arrest Date:_____ Did you serve time? ☐ Yes ☐ No

If yes, Prison or Jail? ☐ Jail ☐ Prison

Arrest Charge: :_____Were you convicted? ☐ Yes ☐ No

Arrest Date:_____ Did you serve time? ☐ Yes ☐ No

If yes, Prison or Jail? ☐ Jail ☐ Prison

Are you a Convicted Sex Offender? ☐ Yes ☐ No

Additional Comments to Support Application

_____

_____

_____

Emergency Contact: (Relative or friend's name and number who we can contact in the case of any emergency.)

Name:_____ Phone: _____

Referral Source: Must be completed.

Referring Party: _____ Date: _____

Agency: _____

Type of Program: _____

Agency Address: _____

Agency Phone: _____ FAX: _____

Client's Statement:

All information that I have provided on this application is complete, truthful, and I have answered all questions to the best of my ability.

_____ _____

Client's Signature ***Date***

Referral Checklist: ***(Documentation below must be attached for completion of referral process.)***

☐ Documentation of Homelessness (Letter from referring agency stating homeless status of the client, or, if applicable, a letter from the Shelter.)

☐ Documentation of Disability (Letter from a doctor or other qualified professional that states this person has a disability.)

☐ Current Entitlements (Proof of any current entitlements being received, i.e. pay stubs, award letters, bank statements)

☐ Dually executed Consent to Release Information

☐ Self Sufficiency Matrix form

As the information contained in this application contains protected health information, please mail this form to:

Shannon Frey, CoC Lead
Homeless Alliance for the Lower Shore Continuum of Care
Somerset County Health Department
8928 Signpost Road
Westover, MD 21871

Phone: (443) 523-1815