



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: ____/____/____

- | | |
|-------------------------------------------------------|-----------------------------------------------------------------|
| <input type="radio"/> Full SSN reported | <input type="radio"/> Full date of birth reported |
| <input type="radio"/> Approx. or partial SSN reported | <input type="radio"/> Approx. or partial date of birth reported |
| <input type="radio"/> Client doesn't know | <input type="radio"/> Client doesn't know |
| <input type="radio"/> Client refused | <input type="radio"/> Client refused |

Veteran Status (all adults) No Yes Client doesn't know Client refused

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):

- | | |
|-------------------------------------------------------------------|---------------------------------------------------------------------------|
| <input type="radio"/> Emergency Shelter & motel paid by others | <input type="radio"/> Rental by client w/ VASH subsidy |
| <input type="radio"/> Foster Care Home or group home | <input type="radio"/> Rental by client, w /GPD TIP subsidy |
| <input type="radio"/> Hospital (non-psychiatric) | <input type="radio"/> Rental by client, w/other ongoing housing subsidy |
| <input type="radio"/> Hotel/Motel (w/o emergency shelter voucher) | <input type="radio"/> Residential /halfway house w/no homeless criteria |
| <input type="radio"/> Jail, prison or juvenile detention fac. | <input type="radio"/> Safe Haven |
| <input type="radio"/> Long Term care facility/nursing home | <input type="radio"/> Staying or living in family's room, apt. or house |
| <input type="radio"/> Owned by Client, no ongoing subsidy | <input type="radio"/> Staying or living in friend's room, apt. or house |
| <input type="radio"/> Owned by Client, with ongoing subsidy | <input type="radio"/> Substances abuse treatment facility or detox center |
| <input type="radio"/> Permanent housing (CoC project) | <input type="radio"/> Transitional homeless housing (incl. unacc. |

youth)

- | | |
|----------------------------------------------------------------|----------------------------------------------|
| <input type="radio"/> Place not meant for Habitation | <input type="radio"/> Other (Describe) _____ |
| <input type="radio"/> Psychiatric hospital or other Psyc. Fac. | <input type="radio"/> Client doesn't know |
| <input type="radio"/> Rental by client, no ongoing subsidy | <input type="radio"/> 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. Pension _____
- 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
- TANF Transportation Services
- 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 a 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 a 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.

<i>Location</i>	<i>Treatment Start Date</i>	<i>Treatment End Date</i>

Are you currently on medication? Yes No

Do you take them as prescribed? Yes No

<i>Please list any current medications:</i>	<i>Dosage</i>	<i>Frequency</i>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Medical History:

Current Medical Issues: _____

Name of Primary Care Provider: _____

Address: _____ Phone: _____

<i>Please list any current medications:</i>	<i>Dosage</i>	<i>Frequency</i>
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: _____

	<i>Location</i>	<i>Date</i>	<i>Location</i>	<i>Date</i>
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arrest Date: _____	Did you serve time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<i>If yes, Prison or Jail?</i>	<input type="checkbox"/> Jail	<input type="checkbox"/> Prison

Arrest Charge: _____	Were you convicted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arrest Date: _____	Did you serve time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<i>If yes, Prison or Jail?</i>	<input type="checkbox"/> Jail	<input type="checkbox"/> Prison

Arrest Charge: : _____	Were you convicted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arrest Date: _____	Did you serve time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<i>If yes, Prison or Jail?</i>	<input type="checkbox"/> Jail	<input type="checkbox"/> 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 send all paperwork through secure email to Shannon Frey at shannon.frey@maryland.gov.