

**SECTION 1: INTAKE for HEAD of HOUSEHOLD (1 of 4)**

Date of Intake:	/ /	
First and Last Name:		
Social Security Number (SSN):		
Veteran?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Household Type:	<input type="checkbox"/> Single Individual <input type="checkbox"/> Female Single Parent <input type="checkbox"/> Male Single Parent <input type="checkbox"/> Two-Parent Family <input type="checkbox"/> Grandparent(s) and grandchild <input type="checkbox"/> Foster Parents <input type="checkbox"/> Foster Parents <input type="checkbox"/> Non-custodial caregiver <input type="checkbox"/> Other	
Housing Move-in Date:	/ /	
Date of Birth:	/ /	
Gender:	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning <input type="checkbox"/> A gender other than singularly female or male (e.g., non-binary, genderfluid, agender, culturally specific gender)	
Race:	<input type="checkbox"/> American Indian, Alaska Native or Indigenous <input type="checkbox"/> Asian or Asian-American <input type="checkbox"/> Black, African-American or African <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White	
Ethnicity:	<input type="checkbox"/> Non-Hispanic/Non-latin(a)(o)(x) <input type="checkbox"/> Hispanic/Latin(a)(o)(x)	
Primary Language:		
Disabling Condition?	<input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol and Drug Abuse <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> Developmental <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Mental Health <input type="checkbox"/> Physical <input type="checkbox"/> Other <input type="checkbox"/> Vision Impaired <input type="checkbox"/> No Disability <input type="checkbox"/> Client refused	
Health Insurance?	<input type="checkbox"/> COBRA <input type="checkbox"/> Employer Provided <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Private Pay <input type="checkbox"/> SCHIP <input type="checkbox"/> Other <input type="checkbox"/> VA Medical Services <input type="checkbox"/> No Health Insurance <input type="checkbox"/> Client refused	

Income?	<p>\$ _____ Alimony or other spousal support</p> <p>\$ _____ Child support</p> <p>\$ _____ Earned income (wages, salary, etc)</p> <p>\$ _____ General assistance</p> <p>\$ _____ Pension or retirement income</p> <p>\$ _____ Private disability insurance</p> <p>\$ _____ Retirement income from Social Security</p> <p>\$ _____ Self-employment wage</p> <p>\$ _____ Supplemental Security Income (SSI)</p> <p>\$ _____ Social Security Disability Insurance (SSDI)</p> <p>\$ _____ TANF</p> <p>\$ _____ Unemployment insurance</p> <p>\$ _____ VA non-service-connected disability pension</p> <p>\$ _____ VA service-connected disability compensation</p> <p>\$ _____ Worker's compensation</p> <p>\$ _____ Other</p> <p>\$ _____ No income</p>
Non-cash Benefits?	<p><input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)</p> <p><input type="checkbox"/> Special supplemental nutrition program for WIC</p> <p><input type="checkbox"/> TANF child care services    <input type="checkbox"/> TANF transportation services</p> <p><input type="checkbox"/> Other TANF-funded services    <input type="checkbox"/> Other</p>
Prior Living Situation:	<p><u>Institutional Situations</u></p> <p><input type="checkbox"/> Foster care home or foster care group</p> <p><input type="checkbox"/> Hospital or other residential non-psychiatric medical facility</p> <p><input type="checkbox"/> Jail, prison or juvenile detention facility</p> <p><input type="checkbox"/> Long-term care facility or nursing home</p> <p><input type="checkbox"/> Psychiatric hospital or other psychiatric facility</p> <p><input type="checkbox"/> Substance abuse treatment facility or detox center</p> <hr/> <p><u>Temporary and Permanent Situations</u></p> <p><input type="checkbox"/> Hotel or motel paid for without ES voucher</p> <p><input type="checkbox"/> Moved from one HOPWA funded project to HOPWA PH</p> <p><input type="checkbox"/> Moved from one HOPWA funded project to HOPWA TH</p> <p><input type="checkbox"/> Owned by client, with ongoing housing subsidy</p> <p><input type="checkbox"/> Owned by client, no ongoing housing subsidy</p> <p><input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons</p> <p><input type="checkbox"/> Rental by client, with GPD TIP housing subsidy</p> <p><input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based)</p> <p><input type="checkbox"/> Rental by client, with RRH or equivalent subsidy</p>

**SECTION 1: INTAKE for HEAD of HOUSEHOLD (3 of 4)**

**HOUSING STABILITY TEAM: EHA**

	<input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Other: _____
Is HoH a DV victim/ survivor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'Yes', how recent was the last incidence of DV?	<input type="checkbox"/> Within past 3 months <input type="checkbox"/> 3-6 months ago <input type="checkbox"/> 6-12 months <input type="checkbox"/> More than one year ago
If 'Yes', are you currently fleeing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Household size:	
Percent of Median Family Income:	<input type="checkbox"/> 0-30% <input type="checkbox"/> 30-50% <input type="checkbox"/> 50-80% <input type="checkbox"/> Over 80%
Zip Code of Last Permanent Address	

**SECTION 1: INTAKE for HEAD of HOUSEHOLD (4 of 4)**

<p><b>If response to Current Living Situation of Head of Household is under <u>INSTITUTIONAL</u>, complete this section.</b></p>	<p><b>If response to Current Living Situation of Head of Household is under <u>TRANSITIONAL AND PERMANENT HOUSING</u>, complete this section.</b></p>
<p>Length of Stay in Previous Place (the location marked under Residence Prior):</p> <p><input type="checkbox"/> <b>One night or less</b>  <input type="checkbox"/> <b>Two to six nights</b>  <input type="checkbox"/> <b>One week or more, but less than one month</b>  <input type="checkbox"/> <b>One month or more, but less than 90 days</b>  <input type="checkbox"/> 90 days or more, but less than one year  <input type="checkbox"/> One year or longer  <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused</p>	<p>Length of Stay in Previous Place (the location marked under Residence Prior):</p> <p><input type="checkbox"/> <b>One night or less</b>  <input type="checkbox"/> <b>Two to six nights</b>  <input type="checkbox"/> One week or more, but less than one month  <input type="checkbox"/> One month or more, but less than 90 days  <input type="checkbox"/> 90 days or more, but less than one year  <input type="checkbox"/> One year or longer  <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused</p>
<p>→If the response above is <b>less than 90 days</b> (the options in bold), then continue:</p>	<p>→If the response above is <b>less than 7 days</b> (the options in bold), then continue:</p>
<p>On the night before their residence prior situation, did client stay on the streets, emergency shelter or safe haven?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>On the night before their residence prior situation, did client stay on the streets, emergency shelter or safe haven?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>→If response to the question above is <b>Yes</b>, then continue:</p>	<p>→If response to the question above is <b>Yes</b>, then continue:</p>
<p>Approximate date homeless situation began: ____/____/____</p> <p>Number of times the client has been on the streets, in emergency shelter, or Safe Haven in the past three years including today:</p> <p><input type="checkbox"/> One time <input type="checkbox"/> Two times <input type="checkbox"/> Three times <input type="checkbox"/> Four or more times  <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused</p> <p>Total number of months homeless on the street, in emergency shelter or safe haven in the past three years (any day or part of a month is counted as one month):  Months: _____  <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused</p>	<p>Approximate date homeless situation began: ____/____/____</p> <p>Number of times the client has been on the streets, in emergency shelter, or Safe Haven in the past three years including today:</p> <p><input type="checkbox"/> One time <input type="checkbox"/> Two times <input type="checkbox"/> Three times <input type="checkbox"/> Four or more times  <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused</p> <p>Total number of months homeless on the street, in emergency shelter or safe haven in the past three years (any day or part of a month is counted as one month):  Months: _____  <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused</p>

Please make a copy of this page for each additional adult (18+) in the household

Date of Intake:	/ /	
First and Last Name:		
Social Security Number (SSN):		
Veteran?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Household Type:	<input type="checkbox"/> Single individual <input type="checkbox"/> Female single parent <input type="checkbox"/> Male single parent <input type="checkbox"/> Two-parent family <input type="checkbox"/> Grandparent(s) and Child <input type="checkbox"/> Foster parent(s) <input type="checkbox"/> Couple with no children <input type="checkbox"/> Non-custodial caregiver(s) <input type="checkbox"/> Other	
Housing Move-in Date:	/ /	
Date of Birth:	/ /	
Gender:	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning <input type="checkbox"/> A gender other than singularly female or male (e.g., non-binary, genderfluid, agender, culturally specific gender)	
Race:	<input type="checkbox"/> American Indian, Alaska Native or Indigenous <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Asian or Asian-American <input type="checkbox"/> White <input type="checkbox"/> Black, African-American or African	
Ethnicity:	<input type="checkbox"/> Non-Hispanic/Non-latin(a)(o)(x) <input type="checkbox"/> Hispanic/Latin(a)(o)(x)	
Primary Language:		
Disabling Condition?	<input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol and Drug Abuse <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> Developmental <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Mental Health <input type="checkbox"/> Physical <input type="checkbox"/> Other <input type="checkbox"/> Vision Impaired <input type="checkbox"/> No Disability <input type="checkbox"/> Client refused	
Health Insurance?	<input type="checkbox"/> COBRA <input type="checkbox"/> Employer Provided <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Private Pay <input type="checkbox"/> SCHIP <input type="checkbox"/> Other <input type="checkbox"/> VA Medical Services <input type="checkbox"/> No Health Insurance <input type="checkbox"/> Client refused	
Income?	\$_____ Alimony or other spousal support \$_____ Child support \$_____ Earned income (wages, salary, etc) \$_____ General assistance \$_____ Pension or retirement income \$_____ Private disability insurance \$_____ Retirement income from Social Security \$_____ Self-employment wage \$_____ Supplemental Security Income (SSI)	

**SECTION 2: INTAKE for OTHER ADULTS (18+) (2 of 2)**

HOUSING STABILITY TEAM: EHA

	\$ _____ Social Security Disability Insurance (SSDI) \$ _____ TANF \$ _____ Unemployment insurance \$ _____ VA non-service-connected disability pension \$ _____ VA service-connected disability compensation \$ _____ Worker’s compensation \$ _____ Other \$ _____ No income
Non-cash Benefits?	<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) <input type="checkbox"/> Special supplemental nutrition program for WIC <input type="checkbox"/> TANF child care services <input type="checkbox"/> TANF transportation services <input type="checkbox"/> Other TANF-funded services <input type="checkbox"/> Other

**SECTION 3: INTAKE for CHILDREN (1 of 2)**

Please make a copy of this section for each additional child in the household.

Date of Intake:	/ /	
First and Last Name:		
Social Security Number (SSN):		
Veteran?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Household Type:	<input type="checkbox"/> Single individual <input type="checkbox"/> Female single parent <input type="checkbox"/> Male single parent <input type="checkbox"/> Two-parent family <input type="checkbox"/> Grandparent(s) and Child <input type="checkbox"/> Foster parent(s) <input type="checkbox"/> Couple with no children <input type="checkbox"/> Non-custodial caregiver(s) <input type="checkbox"/> Other	
Housing Move-in Date:	/ /	
Date of Birth:	/ /	
Gender:	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning <input type="checkbox"/> A gender other than singularly female or male (e.g., non-binary, genderfluid, agender, culturally specific gender)	
Race:	<input type="checkbox"/> American Indian, Alaska Native or Indigenous <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Asian or Asian-American <input type="checkbox"/> White <input type="checkbox"/> Black, African-American or African	
Ethnicity:	<input type="checkbox"/> Non-Hispanic/Non-latin(a)(o)(x) <input type="checkbox"/> Hispanic/Latin(a)(o)(x)	
Primary Language:		

Disabling Condition?	<input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol and Drug Abuse <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> Developmental <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Mental Health <input type="checkbox"/> Physical <input type="checkbox"/> Other <input type="checkbox"/> Vision Impaired <input type="checkbox"/> No Disability <input type="checkbox"/> Client refused
Health Insurance?	<input type="checkbox"/> COBRA <input type="checkbox"/> Employer Provided <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Private Pay <input type="checkbox"/> SCHIP <input type="checkbox"/> Other <input type="checkbox"/> VA Medical Services <input type="checkbox"/> No Health Insurance <input type="checkbox"/> Client refused

## SECTION 4: SERVICE(S)

The table below should be used to track services a monthly basis. Specify the total amount spent for each Service Type during the specified month.

SERVICE MONTH & YEAR: \_\_\_\_\_

SERVICE TYPE	AMOUNT
Eviction Prevention Legal Assistance	\$
Housing Expense Assistance	\$
Mortgage Expense Assistance	\$
Rental Deposit Assistance	\$
Rent Payment Assistance	\$
Utility Assistance	\$
Other <u>Please specify (required):</u>	\$

## SECTION 5: POST-SERVICE OUTCOME (1 of 2)

HOUSING STABILITY TEAM: EHA

Responses to the following questions, including the Post-Service Living Situation, are required for the Head of Household only.

<p>Will these funds solve your current housing issue?</p> <p>If response is No, what would solve your current housing issue?</p> <hr/>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
<p>Using your best guess, do you think you will need more funds or services over the next six months to stay in your home?</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
<p>Do you feel more stable in your housing as a result of these funds?</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>

### Post-Service

#### Living Situation:

#### Homeless Situations

- Place not meant for habitation
- Emergency shelter, incl. hotel/motel paid for w/ ES voucher, or RHY-funded Host Home shelter
- Safe Haven

#### Institutional Situations

- Foster care home or foster care group
- 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

#### Temporary and Permanent Situations

- Host Home (non-crisis)
- Hotel or motel paid for without ES voucher
- Moved from one HOPWA funded project to HOPWA PH
- Moved from one HOPWA funded project to HOPWA TH
- Owned by client, with ongoing housing subsidy
- Owned by client, no ongoing housing subsidy
- Permanent housing (other than RRH) for formerly homeless persons
- Rental by client, with GPD TIP housing subsidy
- Rental by client, with HCV voucher (tenant or project based)

- Rental by client, with RRH or equivalent subsidy
- Rental by client, with VASH housing subsidy
- Rental by client, with other ongoing housing subsidy
- Rental by client, no ongoing housing subsidy
- Rental by client in a public housing unit
- Residential project or halfway house with no homeless criteria
- Staying or living with family, temporary tenure
- Staying or living with family, permanent tenure
- Staying or living with friend, temporary tenure
- Staying or living with friends, permanent tenure
- Transitional housing for homeless persons (including homeless youth)
- Other: \_\_\_\_\_