

Intake Date: _____ ServicePoint Client ID for Head of Household: _____

Check One:	<input type="checkbox"/> Rapid Re-Housing	<input type="checkbox"/> Housing Choice Voucher
Housing Move-In Date:	Fill in the date and update this field in ServicePoint by adding an Interim Review when household has been placed in permanent housing: _____/_____/_____	

Household Size: _____
Household Type: <input type="checkbox"/> Single Individual <input type="checkbox"/> Female Single Parent <input type="checkbox"/> Male Single Parent <input type="checkbox"/> Two Parent <input type="checkbox"/> Foster Parent(s) <input type="checkbox"/> Grandparent(s) w/ children <input type="checkbox"/> Couple with No Children <input type="checkbox"/> Non-custodial Caregiver <input type="checkbox"/> Other: _____

HEAD OF HOUSEHOLD (HoH) Data (Page 1 of 3)

Name: _____			DOB: _____			Rel. to HoH: <u>SELF</u>		
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Gender other than singularly Male or Female <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused								
Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know			Primary Language: _____			Zip Code of last permanent address: _____		
Inclusive Identity* (check all that apply):			Ethnicity:					
<input type="checkbox"/> African			<input type="checkbox"/> Native Am/Alaska Native			<input type="checkbox"/> Non-Hispanic/Non-Latino		
<input type="checkbox"/> Asian			<input type="checkbox"/> Native Hawaiian/Pacific Islander			<input type="checkbox"/> Hispanic/Latino		
<input type="checkbox"/> Black/African American			<input type="checkbox"/> Slavic			<input type="checkbox"/> Client Doesn't Know		
<input type="checkbox"/> Latino/Hispanic			<input type="checkbox"/> White			<input type="checkbox"/> Client Refused		
<input type="checkbox"/> Middle Eastern			<input type="checkbox"/> Declined to Answer					
* When entering data in ServicePoint, you will need to enter these responses under BOTH the Inclusive Identity as well as Federal race/ethnicity categories areas.								
Disability Type: <input type="checkbox"/> None <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Mental Health <input type="checkbox"/> Physical <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Vision Impaired <input type="checkbox"/> Developmental <input type="checkbox"/> Other: _____								
Health Insurance: <input type="checkbox"/> None <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Medicaid (OHP) <input type="checkbox"/> Medicare <input type="checkbox"/> VA Medical Services <input type="checkbox"/> Employer Provided <input type="checkbox"/> COBRA <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Private Pay <input type="checkbox"/> Other: _____								
Continuous and Ongoing Non-Cash Benefits: (Select all that apply) <input type="checkbox"/> None <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Supplemental Nutrition Assistance (SNAP) <input type="checkbox"/> 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 (Describe): _____								

HEAD OF HOUSEHOLD (HoH) Data (Page 2 of 3)

Continuous and Ongoing Income (Fill in all that apply. Do not count if income is one time, has ended, or is ending soon):

None Client Refused Client Doesn't Know

Monthly Amount	Monthly Amount
\$_____ Alimony or Other Spousal Support	\$_____ Supplemental Security Income (SSI)
\$_____ Child Support	\$_____ TANF
\$_____ Earned Income (wages, salary, etc)	\$_____ Unemployment Insurance
\$_____ General Assistance	\$_____ VA Non-Service Connected Disability Pension
\$_____ Pension or retirement income	\$_____ VA Service Connected Disability Compensation
\$_____ Private Disability Insurance	\$_____ Worker's Compensation
\$_____ Retirement Income from Social Security	\$_____ Other: _____
\$_____ Social Security Disability Insurance (SSDI)	_____

Employment Status: Full-Time Part-Time Job Training Irregular
Not Employed – Not Seeking Not Employed – Seeking Retired

DV Survivor? Yes No Client Refused Client Doesn't Know

If response is **Yes**:

When did the experience occur? Within past 3 months 3-6 months ago More than a year ago
Client Refused Client Doesn't Know

Are you currently fleeing? Yes No

Population A/B **Required for Head of Household: see Population A/B Determination Form**

Population A

Population B

HEAD OF HOUSEHOLD (HoH) Data (Page 2.5 of 3)

Residence Prior to Program Entry: (Select only ONE)

HOMELESS SITUATION	INSTITUTIONAL SITUATION	TEMPORARY AND PERMANENT HOUSING SITUATION
<input type="checkbox"/> Place not meant for habitation <input type="checkbox"/> Emergency Shelter, including hotel or motel paid for <u>with</u> emergency shelter voucher <input type="checkbox"/> Safe Haven	<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for <u>without</u> emergency shelter voucher <input type="checkbox"/> Transitional Housing for homeless persons (including homeless youth) <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Rental by client, with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with VASH subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not collected

HEAD OF HOUSEHOLD (HoH) Data (Page 3 of 3)

<p>If response to Residence Prior to Program Entry is under <u>HOMELESS</u>, complete this section.</p>	<p>If response to Residence Prior to Program Entry is under <u>INSTITUTIONAL</u>, complete this section.</p>	<p>If response to Residence Prior to Program Entry is under <u>TRANSITIONAL AND PERMANENT HOUSING</u>, complete this section.</p>
<p>Length of Stay in Previous Place (the location marked under Residence Prior):</p> <p><input type="checkbox"/>One night or less <input type="checkbox"/>Two to six nights <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>Length of Stay in Previous Place (the location marked under Residence Prior):</p> <p><input type="checkbox"/>One night or less <input type="checkbox"/>Two to six nights <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>Length of Stay in Previous Place (the location marked under Residence Prior):</p> <p><input type="checkbox"/>One night or less <input type="checkbox"/>Two to six nights <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>Approximate date homeless: _____</p>	<p>→If the response above is less than 90 days (the options in bold), then continue:</p>	<p>→If the response above is less than 7 days (the options in bold), then continue:</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>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 Yes, then continue:</p>	<p>→If response to the question above is Yes, then continue:</p>	<p>→If response to the question above is Yes, then continue:</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>	<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>

For each additional adult in the household, please make copies of these pages.

OTHER ADULT (18+ yrs of age) Data (Page 1 of 3)

Name: _____		DOB: _____	
Relationship to Head of Household (HoH):			
<input type="checkbox"/> Head of household's spouse or partner <input type="checkbox"/> Head of household's child <input type="checkbox"/> Head of household's other relation member (other relation to HoH) <input type="checkbox"/> Other: Non-relation member			
Gender:			
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Gender other than singularly Male or Female <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused			
Veteran?		Primary Language:	Zip Code of last permanent address:
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know		_____	_____
Inclusive Identity* (check all that apply):		Ethnicity:	
<input type="checkbox"/> African <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Middle Eastern		<input type="checkbox"/> Native Am/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Slavic <input type="checkbox"/> White <input type="checkbox"/> Declined to Answer	
		<input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
* When entering data in ServicePoint, you will need to enter these responses under BOTH the Inclusive Identity as well as Federal race/ethnicity categories sections.			
Disability Type:			
<input type="checkbox"/> None <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Mental Health <input type="checkbox"/> Physical <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Vision Impaired <input type="checkbox"/> Developmental <input type="checkbox"/> Other: _____			
Health Insurance:			
<input type="checkbox"/> None <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Medicaid (OHP) <input type="checkbox"/> Medicare <input type="checkbox"/> VA Medical Services <input type="checkbox"/> Employer Provided <input type="checkbox"/> COBRA <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Private Pay <input type="checkbox"/> Other: _____			
Continuous and Ongoing Non-Cash Benefits:			
(Select all that apply) <input type="checkbox"/> None <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Supplemental Nutrition Assistance (SNAP) <input type="checkbox"/> 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 (Describe): _____			

OTHER ADULT (18+ yrs of age) Data (Page 2 of 3)

Continuous and Ongoing Income (Fill in all that apply. Do not count if income is one time, has ended, or is ending soon):

None Client Refused Client Doesn't Know

Monthly Amount		Monthly Amount	
\$ _____	Alimony or Other Spousal Suport	\$ _____	Supplemental Security Income (SSI)
\$ _____	Child Support	\$ _____	TANF
\$ _____	Earned Income (wages, salary, etc)	\$ _____	Unemployment Insurance
\$ _____	General Assistance	\$ _____	VA Non-Service Connected Disability Pension
\$ _____	Pension or retirement income	\$ _____	VA Service Connected Disability Compensation
\$ _____	Private Disability Insurance	\$ _____	Worker's Compensation
\$ _____	Retirement Income from Social Security	\$ _____	Other:
\$ _____	Social Security Disability Insurance (SSDI)		_____

Employment Status: Full-Time Part-Time Job Training Irregular
Not Employed – Not Seeking Not Employed – Seeking Retired

DV Survivor? Yes No Client Refused Client Doesn't Know

If response is **Yes**:

When did the experience occur? Within past 3 months 3-6 months ago More than a year ago
Client Refused Client Doesn't Know

Are you currently fleeing? Yes No

OTHER ADULT (18+ yrs of age) Data (Page 2.5 of 3)**Residence Prior to Program Entry: (Select only ONE)****HOMELESS SITUATION**

- Place not meant for habitation
- Emergency Shelter, including hotel or motel paid for with emergency shelter voucher
- Safe Haven

INSTITUTIONAL SITUATION

- 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

TEMPORARY AND PERMANENT HOUSING SITUATION

- Residential project or halfway house with no homeless criteria
- Hotel or motel paid for without emergency shelter voucher
- Transitional Housing for homeless persons (including homeless youth)
- Host Home (non-crisis)
- Staying or living in a friend's room, apartment or house
- Staying or living in a family member's room, apartment or house
- Rental by client, with GPD TIP housing subsidy
- Rental by client, with VASH subsidy
- Permanent housing (other than RRH) for formerly homeless persons
- Rental by client, with RRH or equivalent subsidy
- Rental by client, with HCV voucher (tenant or project based)
- Rental by client in a public housing unit

- Rental by client, no ongoing housing subsidy
- Rental by client, with other ongoing housing subsidy
- Rental by client in a public housing unit
- Owned by client, with ongoing housing subsidy
- Owned by client, no ongoing housing subsidy

- Client Doesn't Know Client Refused Data not collected

OTHER ADULT (18+ yrs of age) Data (Page 3 of 3)

<p>If response to Residence Prior to Program Entry is under <u>HOMELESS</u>, complete this section.</p>	<p>If response to Residence Prior to Program Entry is under <u>INSTITUTIONAL</u>, complete this section.</p>	<p>If response to Residence Prior to Program Entry is under <u>TRANSITIONAL AND PERMANENT HOUSING</u>, complete this section.</p>
<p>Length of Stay in Previous Place (the location marked under Residence Prior):</p> <p><input type="checkbox"/>One night or less <input type="checkbox"/>Two to six nights <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>Length of Stay in Previous Place (the location marked under Residence Prior):</p> <p><input type="checkbox"/>One night or less <input type="checkbox"/>Two to six nights <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>Length of Stay in Previous Place (the location marked under Residence Prior):</p> <p><input type="checkbox"/>One night or less <input type="checkbox"/>Two to six nights <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>Approximate date homeless: _____</p>	<p>→If the response above is less than 90 days (the options in bold), then continue:</p>	<p>→If the response above is less than 7 days (the options in bold), then continue:</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>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 Yes, then continue:</p>	<p>→If response to the question above is Yes, then continue:</p>	<p>→If response to the question above is Yes, then continue:</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>	<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>

CHILD (under 18 years of age) Data (Page 1 of 1)

Name: _____		DOB: _____	
Relationship to Head of Household (HoH):			
<input type="checkbox"/> Head of household's spouse or partner <input type="checkbox"/> Head of household's child <input type="checkbox"/> Head of household's other relation member (other relation to HoH) <input type="checkbox"/> Other: Non-relation member			
Gender:			
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Gender other than singularly Male or Female <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused			
Primary Language: _____			
Inclusive Identity* (check all that apply):		Ethnicity:	
<input type="checkbox"/> African <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Middle Eastern		<input type="checkbox"/> Native Am/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Slavic <input type="checkbox"/> White <input type="checkbox"/> Declined to Answer	
		<input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
* When entering data in ServicePoint, you will need to enter these responses under BOTH the Inclusive Identity as well as Federal race/ethnicity categories sections.			
Disability Type:			
<input type="checkbox"/> None <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Mental Health <input type="checkbox"/> Physical <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Vision Impaired <input type="checkbox"/> Developmental <input type="checkbox"/> Other: _____			
Health Insurance:			
<input type="checkbox"/> None <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Medicaid (OHP) <input type="checkbox"/> Medicare <input type="checkbox"/> VA Medical Services <input type="checkbox"/> Employer Provided <input type="checkbox"/> COBRA <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Private Pay <input type="checkbox"/> Other: _____			

I certify that the information on this intake packet for this entire household is true and accurate to the best of my knowledge.

Client Signature _____ Date _____

Case Worker/Agency Staff Signature _____ Date _____

For each additional child in the household, please make copies of this page.

CHILD (under 18 years of age) Data (Page 1 of 1)

Name: _____		DOB: _____	
Relationship to Head of Household (HoH):			
<input type="checkbox"/> Head of household's spouse or partner <input type="checkbox"/> Head of household's child <input type="checkbox"/> Head of household's other relation member (other relation to HoH) <input type="checkbox"/> Other: Non-relation member			
Gender:			
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Gender other than singularly Male or Female <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused			
Primary Language: _____			
Inclusive Identity* (check all that apply):		Ethnicity:	
<input type="checkbox"/> African <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Middle Eastern		<input type="checkbox"/> Native Am/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Slavic <input type="checkbox"/> White <input type="checkbox"/> Declined to Answer	
		<input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
<p>* When entering data in ServicePoint, you will need to enter these responses under BOTH the Inclusive Identity as well as Federal race/ethnicity categories sections.</p>			
Disability Type:			
<input type="checkbox"/> None <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Mental Health <input type="checkbox"/> Physical <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Vision Impaired <input type="checkbox"/> Developmental <input type="checkbox"/> Other: _____			
Health Insurance:			
<input type="checkbox"/> None <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Medicaid (OHP) <input type="checkbox"/> Medicare <input type="checkbox"/> VA Medical Services <input type="checkbox"/> Employer Provided <input type="checkbox"/> COBRA <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Private Pay <input type="checkbox"/> Other: _____			