



1. Intake Information

Intake Date ____/____/____ MM DD YYYY	Intake Staff Name _____
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2. Additional Household Member (AHM) Information

Name (First, Middle, Last, Suffix)			
Alias/AKA		Client ID (HMIS Assigned)	
Relationship to Head of Household		Household ID (HMIS Assigned)	
SSN	____-____-____ <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	Date of Birth	____/____/____ <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
Race and Ethnicity Select as many as are applicable:	<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"/> Hispanic/Latina/e/o <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer Additional Race and Ethnicity Detail:	Gender Select as many as are applicable:	<input type="checkbox"/> Woman (Girl, if child) <input type="checkbox"/> Man (Boy, if child) <input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit) <input type="checkbox"/> Transgender <input type="checkbox"/> Non-Binary <input type="checkbox"/> Questioning <input type="checkbox"/> Different Identity Specify: <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
Sexual Orientation (Required for YHDP and RHY projects)	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Other Specify: <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	Veteran Status	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
Survivor of Domestic Violence	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
If Yes, When experience occurred:	<input type="checkbox"/> Within the past three months <input type="checkbox"/> 3 to 6 months ago (excluding 6 months exactly) <input type="checkbox"/> 6 to 12 months ago (excluding one year exactly) <input type="checkbox"/> One year ago, or more		<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
If Yes, Are you currently fleeing?	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer



3. Prior Living Situation

<p>What was the situation the client was living in immediately prior to project entry?</p> <p>Complete parts A, B, and C for clients whose prior living situation is different than their Head of Household</p>	A) Prior Living Situation	
	<p>Homeless Situations</p> <p><input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, or anywhere outside)</p> <p><input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home Shelter</p> <p><input type="checkbox"/> Safe Haven</p> <p>Institutional Situations</p> <p><input type="checkbox"/> Foster care home or FC group home</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 psych facility</p> <p><input type="checkbox"/> Substance abuse treatment facility or detox center</p> <p>Other</p> <p><input type="checkbox"/> Client doesn't know</p>	<p>Temporary Housing Situations</p> <p><input type="checkbox"/> Transitional housing for homeless persons (including youth)</p> <p><input type="checkbox"/> Residential project or halfway house with no homeless criteria</p> <p><input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher</p> <p><input type="checkbox"/> Host Home (non-crisis)</p> <p><input type="checkbox"/> Staying in a friend's room, apartment, or house</p> <p><input type="checkbox"/> Staying or living in a family member's room, apartment, or house</p> <p>Permanent Housing Situations</p> <p><input type="checkbox"/> Rental by client:</p> <p style="padding-left: 20px;"><input type="checkbox"/> No ongoing housing subsidy</p> <p style="padding-left: 20px;"><input type="checkbox"/> Ongoing housing subsidy</p> <p style="padding-left: 20px;">Subsidy Type: _____</p> <p><input type="checkbox"/> Owned by client:</p> <p style="padding-left: 20px;"><input type="checkbox"/> No ongoing housing subsidy</p> <p style="padding-left: 20px;"><input type="checkbox"/> Ongoing housing subsidy</p> <p><input type="checkbox"/> Client prefers not to answer</p>
	B) Length of Stay in Previous Place	
	<p><input type="checkbox"/> One night or less</p> <p><input type="checkbox"/> Two to six nights</p> <p><input type="checkbox"/> One week or more, but less than one month</p> <p><input type="checkbox"/> One month or more, but less than 90 days</p>	<p><input type="checkbox"/> 90 days or more, but less than one year</p> <p><input type="checkbox"/> One year or longer</p> <p><input type="checkbox"/> Client doesn't know</p> <p><input type="checkbox"/> Client prefers not to answer</p>

C) Date Client started being homeless on the streets, in a shelter, or safe haven

Determine the date of the last time the client had a place to sleep that was not on the streets, in an emergency shelter, or in a safe haven. As the client looks back, there may be breaks in their stay at these locations.

The breaks are allowed to be included in the look back period to calculate the start date only if:

- The client moved continuously between the streets, shelters, or safe havens. The date would go back as far as the first time they stayed in one of those places; OR
- The break in their time on the streets, shelters, or safe havens was less than 7 nights. The time homeless would not be broken by a stay less than 7 consecutive nights; OR
- The break in their time on the streets, shelters, or safe havens was less than 90 days in any of the places listed as "institutional situations." The time homeless would not be broken by a stay less than 90 consecutive nights.

Approximate date current episode of homelessness started		_____/_____/_____	
<p>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?</p>	<p><input type="checkbox"/> One time</p> <p><input type="checkbox"/> Two times</p> <p><input type="checkbox"/> Three times</p> <p><input type="checkbox"/> Four or more times</p> <p><input type="checkbox"/> Client doesn't know</p> <p><input type="checkbox"/> Client prefers not to answer</p>	<p>Total number of months homeless on the street, in ES or SH in the past three years.</p>	<p><input type="checkbox"/> One month (this time is the first month)</p> <p><input type="checkbox"/> 2-12 months (# _____)</p> <p><input type="checkbox"/> More than 12 months</p> <p><input type="checkbox"/> Client doesn't know</p> <p><input type="checkbox"/> Client prefers not to answer</p>



4. Income Information (optional for ESG ES Night-by-Night and ESG RUSH ES and SO projects)

Monthly Income at Intake	If Yes, indicate the amount of income from each source:	Amount
Does the client have income from any source? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer If this client is a minor, their income should be reported on the Head of Household's record.	<input type="checkbox"/> Earned Income (i.e., employment income)	
	<input type="checkbox"/> Unemployment Insurance	
	<input type="checkbox"/> Supplemental Security Income (SSI)	
	<input type="checkbox"/> Social Security Disability Insurance (SSDI)	
	<input type="checkbox"/> VA Non-Service-Connected Disability Pension	
	<input type="checkbox"/> Private disability insurance	
	<input type="checkbox"/> Worker's Compensation	
	<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)	
	<input type="checkbox"/> General Assistance (GA)	
	<input type="checkbox"/> Retirement from Social Security	
	<input type="checkbox"/> Pension or retirement income from a former job	
	<input type="checkbox"/> Child support	
	<input type="checkbox"/> Alimony or other spousal support	
	<input type="checkbox"/> Other source – Specify:	
Total Monthly Income:		\$ _____

5. Non-Cash Benefits Information (optional for ESG ES Night-by-Night and ESG RUSH ES and SO projects)

Non-Cash Benefits at Intake	If Yes, indicate all sources that apply:
Does the client have non-cash benefits from any source? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer If this client is a minor, their non-cash benefits should be reported on the Head of Household's record.	<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) <i>Previously known as Food Stamps</i>
	<input type="checkbox"/> Special Supplemental Nutrition Program Women, Infants, and Children (WIC)
	<input type="checkbox"/> TANF Childcare Services
	<input type="checkbox"/> TANF Transportation Services
	<input type="checkbox"/> Other TANF-funded services
	<input type="checkbox"/> Other source – Specify:

6. Insurance Information (optional for ESG ES Night-by-Night and ESG RUSH ES and SO projects)

Health Insurance at Intake	If Yes, indicate all sources that apply:
Is the client covered by Health Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> MEDICAID
	<input type="checkbox"/> MEDICARE
	<input type="checkbox"/> State Children's Health Insurance Program
	<input type="checkbox"/> Veteran's Health Administration (VHA)
	<input type="checkbox"/> Employer-Provided Health Insurance
	<input type="checkbox"/> Health Insurance obtained through COBRA
	<input type="checkbox"/> Private Pay Health Insurance
	<input type="checkbox"/> State Health Insurance for Adults
	<input type="checkbox"/> Indian Health Services Program
	<input type="checkbox"/> Other source - Specify:



7. Disability Information

Disability Information at Intake	If yes, indicate all that apply: (optional for ESG ES Night-by-Night and ESG RUSH ES and SO projects)	Is the disability expected to be of long, continued, indefinite duration and substantially impairs the client's ability to live independently?
Does the client have a disabling condition? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Physical Disability	<input type="checkbox"/>
	<input type="checkbox"/> Developmental Disability	<input type="checkbox"/>
	<input type="checkbox"/> Chronic Health Condition	<input type="checkbox"/>
	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/>
	<input type="checkbox"/> Mental Health Disorder	<input type="checkbox"/>
	<input type="checkbox"/> Substance Use Disorder	<input type="checkbox"/>

8. Translation Assistance Information

Translation Need	If yes, indicate their preferred language:
Does the client need translation assistance? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	

9. Date of Engagement (required for ES Night-by-Night and SO only)

Date of Engagement
Enter the date the client was administered an assessment or began a case plan. Leave blank until engagement has occurred. <div style="text-align: center; margin-top: 10px;"> _____ / _____ / _____ MM DD YYYY </div>

10. Locally Required Elements (NY-508)

Primary Reason Homeless, if different from Head of Household:	
<input type="checkbox"/> Aged out of foster care <input type="checkbox"/> Asked to leave by landlord <input type="checkbox"/> Court eviction by landlord <input type="checkbox"/> Domestic Violence (DV) <input type="checkbox"/> Eviction by primary tenant <input type="checkbox"/> Fire or natural disaster <input type="checkbox"/> Health/Safety violation <input type="checkbox"/> Household dispute (not DV) <input type="checkbox"/> Loss of job/income (includes public benefits) <input type="checkbox"/> Medical Condition	<input type="checkbox"/> Mental Health <input type="checkbox"/> Mortgage foreclosure on rental property lived in <input type="checkbox"/> Mortgage foreclosure of own home <input type="checkbox"/> Problems with building <input type="checkbox"/> Problems with landlord <input type="checkbox"/> Release from institution <input type="checkbox"/> Relocation from out of the NY-508 CoC area <input type="checkbox"/> Substance Use <input type="checkbox"/> Utility shut-off/arrears <input type="checkbox"/> Violence/Assault (not DV)
Zip Code of Last Permanent Address, if different from Head of Household:	

Signatures

I hereby certify that, to the best of my knowledge, the provided information is true and accurate.

Client Signature: _____ **Date:** ____ / ____ / ____

Intake Worker Signature: _____ **Date:** ____ / ____ / ____