**1. Intake Summary**

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| **Intake Date** \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_ MM DD YYYY  | **Intake Staff Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**2. Household Information** *(****\*only complete this section if you have a family or household****)*

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| **Household Type** | 🞏 Couple with no children🞏 Two Parent Family🞏 Female Single Parent | 🞏 Male Single Parent🞏 Foster Parent(s)🞏 Non-Custodial Caregiver(s) | 🞏 Grandparent(s) and Child🞏 Single🞏 Other |

**Head of Household** *(Note: You must complete all data elements for each household member)*

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| **First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suffix\_\_\_\_\_\_** |
| **Client ID (ServicePoint Assigned)****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **DOB****\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_** | **Relationship to Head of Household****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Household Member #1** *(Note: You must complete all fields for each household member)*

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| **First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suffix\_\_\_\_\_\_** |
| **Client ID (ServicePoint Assigned)****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **DOB****\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_** | **Relationship to Head of Household****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Household Member #2** *(Note: You must complete all fields for each household member)*

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| **First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suffix\_\_\_\_\_\_** |
| **Client ID (ServicePoint Assigned)****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **DOB****\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_** | **Relationship to Head of Household****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Household Member #3** *(Note: You must complete all fields for each household member)*

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| **First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suffix\_\_\_\_\_\_** |
| **Client ID (ServicePoint Assigned)****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **DOB****\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_** | **Relationship to Head of Household****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**3. Basic Client Profile**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Project Start Date: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**(Head of Household)**

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| **SS#** | \_\_\_\_\_\_\_\_\_\_\_\_- \_\_\_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date of Birth** | \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Race** | Primary Secondary🞏 🞏 American Indian or Alaska Native🞏 🞏 Asian🞏 🞏 Black or African-American🞏 🞏 Native Hawaiian or Pacific Island🞏 🞏 White🞏 🞏 Client Doesn’t Know🞏 🞏 Client Refused | **Ethnicity** | 🞏 Non-Hispanic/Latino🞏 Hispanic/Latino🞏 Client Doesn’t Know🞏 Client Refused |
| **Gender** | 🞏 Male 🞏 Female 🞏 Trans Male (FTM or Female to Male)🞏 Trans Female (MTF or Male to Female)🞏 Gender Non-Conforming🞏 Client Doesn’t Know 🞏 Client Refused  | **Sexual Orientation** | 🞏Heterosexual🞏Gay🞏Lesbian🞏Bisexual🞏Questioning/Unsure🞏Client Doesn’t Know🞏Client Refused |

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| **Relationship To Head of Household** | 🞏 Self (head of household)🞏 Head of household’s child🞏 Head of household’s spouse or partner | 🞏 Head of household’s other relation member (other relation to head of household)🞏 Other: non-relation member |
| **Client Location Code** | 🞏 NY 508 Erie/Niagara/Genesee/Orleans/Wyoming🞏 NY 504 Cattaraugus | **US Military Veteran** | 🞏 Yes 🞏 No 🞏 Client Doesn’t Know 🞏 Client Refused |

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| HEALTH INSURANCE AT START(Everyone) |
| **Covered By Health Insurance?**Yes No Client Doesn’t Know Client RefusedStart Date: \_\_\_\_\_\_\_\_\_\_\_\_\_End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Source of Non-Cash Benefit**Medicaid MedicareState Children’s Health Insurance ProgramVeteran’s (VA) Medical Services | Employer-Provided Health InsuranceHealth Insurance Obtained Through COBRAPrivate Pay Health InsuranceState Health Insurance For AdultsIndian Health Services Program |

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| **Disability Information at start** (Everyone) |
| **Long term Disabling Condition**Yes No Client Doesn’t Know Client Refused |
| **Disability Determination** Yes No Client Doesn’t Know Client Refused |
| **Disability Type:**  | Is the disability expected to be of long, continued, indefinite duration and substantially impairs the client’s ability to live independently? | Start Date |
| Physical Disability | Yes No Client Doesn’t Know Client Refused |  |
| Developmental Disability | Yes No Client Doesn’t Know Client Refused |  |
| Substance Abuse | Yes No Client Doesn’t Know Client Refused |  |
| Chronic Health Condition | Yes No Client Doesn’t Know Client Refused |  |
| Mental Health | Yes No Client Doesn’t Know Client Refused |  |
| HIV/AIDS  | Yes No Client Doesn’t Know Client Refused |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes No Client Doesn’t Know Client Refused |  |
| Notes: |

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| MONTHLY INCOME At Start(Dependent Income recorded under Head of Household in HMIS) |
| **Income Received from any source**Yes No Client Doesn’t Know Client RefusedIf yes, Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_(Needed For Each Income Source)**Total Monthly Income** $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Source of Income**Earned Income $\_\_\_\_\_\_\_\_\_Unemployment Insurance $\_\_\_\_\_\_\_\_\_Supplemental Security Income (SSI):$\_\_\_\_\_\_\_\_\_Social Security Disability Income (SSDI):$\_\_\_\_\_\_\_\_\_VA Service-Connected Disability Pension $\_\_\_\_\_\_\_\_\_Private Disability Insurance $\_\_\_\_\_\_\_\_\_Worker’s Compensation $\_\_\_\_\_\_\_\_\_Temporary Assistance for Needy Families (TANF):$\_\_\_\_\_\_\_\_\_ | General Assistance (GA) $\_\_\_\_\_\_\_\_\_Retirement from Social Security $\_\_\_\_\_\_\_\_\_Veteran’s Non-Service-Connected Disability Pension $\_\_\_\_\_\_\_\_Pension or Retirement from Former Job $\_\_\_\_\_\_\_\_Child Support $\_\_\_\_\_\_\_\_Alimony/Other Spousal Support $\_\_\_\_\_\_\_\_Other Sources: If Other: Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_$\_\_\_\_\_\_\_\_ |

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| NON-CASH BENEFITS AT START (Dependent Benefits recorded under Head of Household in HMIS) |
| **Non-Cash Benefits from any source**Yes No Client Doesn’t Know Client RefusedIf yes, Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Source of Non-Cash Benefit**Food Stamps- Supplemental Nutrition Assistance Program Special Supplemental Nutrition Program for WICTANF Child Care ServicesTANF Transportation Services | Other TANF-Funded ServicesOther Source \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Temporary rental assistance (retired) |
| **Residence Prior to Project Entry**What was the situation the client was living in immediately prior to project entry?**Complete parts A & B of this question, then determine if part C is needed based on your client’s length of stay.** |  **A) Prior Living Situation****Choose One (1)** | **B) Length of Stay in Prior Living Situation** |
| **Literally Homeless Situation** 🞏 Place not meant for habitation (e.g., a vehicle, abandoned building, bus/train/subway station or anywhere outside)🞏 Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home Shelter🞏 Safe Haven  | 🞏 One night or less🞏 Two to Six nights🞏 More than one week, but less than one month🞏 One month or more but less than 90 days🞏More than 90 days, but less than one year🞏 One year or longer🞏 Client Doesn’t Know🞏 Client Refused | Regardless the Length of Stay, complete PART C on the next page |
| **Institutional Situation** 🞏 Foster care of 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  | 🞏 One night or less🞏 Two to Six nights🞏 More than one week, but less than one month🞏 One month or more but less than 90 days🞏More than 90 days, but less than one year🞏 One year or longer🞏 Client Doesn’t Know🞏 Client Refused | If length of stay is less than 90 days, complete PART C on the next pageIf length of stay is 90 days or more, **STOP**. Do not complete part C |
| **Transitional and Permanent Situations** 🞏Residential project or halfway house with no homeless criteria 🞏Hotel or motel paid for without emergency shelter voucher 🞏Transitional housing for homeless persons (including 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 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🞏Rental by client in public housing unit🞏Rental by client, no ongoing housing subsidy 🞏Rental by client, with other ongoing subsidy 🞏Owned by client, no ongoing housing subsidy 🞏Owned by client, with ongoing housing subsidy  | 🞏 One night or less🞏 Two to Six nights🞏 More than one week, but less than one month🞏 One month or more but less than 90 days🞏More than 90 days, but less than one year🞏 One year or longer🞏 Client Doesn’t Know🞏 Client Refused | If length of stay is 6 nights or less, complete PART C on the next pageIf length of stay is 7 nights or more, **STOP**. Do not complete part C |
| 🞏 **Client Doesn’t Know, Client Refused, Data Not Collected** |  |

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| **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 on the streets, shelters, or safe havens. 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. A break is considered 6 or less consecutive nights not residing in a place not meant for human habitation, in shelter or in a safe haven. The look back time would not be broken by a stay less than 7 consecutive nights; OR
* The break in their time on the streets, ES, or SH was less than 90 days in any of the places listed under the header “institutional situations” on the previous page. The look back time would include all of those days (up to 89 days) when looking back for the start date.
 |
| **Approximate Date Last Episode of Homelessness****Started** | \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ | **How many times has the client has been homeless on the streets, in ES, or SH in the past three years including this time?** | 🞏 One time (This time)🞏 Two times🞏 Three times🞏 Four or more times🞏 Client Doesn’t Know🞏 Client Refused  |
| **Total number of months homeless on the street, in ES, or SH in the past three years.** | 🞏 One month or less (First time homeless)🞏 2-12 months (# months\_\_\_\_\_\_)🞏 More than 12 months🞏 Client Doesn’t Know🞏 Client Refused | A break in homelessness separating the occasions means at least 7 consecutive nights of not living on the street, in an emergency shelter, or Safe Haven or at least 90 days in any of the places listed under the header “institutional situations” on the previous page. |

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| **If prior living situation is emergency shelter, please select the prior emergency shelter** | 🞏 Altamont🞏 Buffalo City Mission🞏 Casey House Teen Shelter🞏 Compass House🞏 Cornerstone🞏 DSS Hotel Placement🞏 Faith-Based Fellowship🞏 Family Promise🞏 Haven House—Emergency Shelter🞏 Little Portion Friary | 🞏 Niagara Gospel Rescue Mission🞏 PASSAGE House DV Shelter🞏 Salvation Army🞏 Shelter outside of Erie/Niagara County🞏 St. Luke’s🞏 Temple of Christ🞏 TSI-Emergency Shelter🞏 YWCA Niagara Shelter🞏 Niagara Community Mission—ES |

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| **Domestic Violence victim/****survivor** | 🞏 Yes 🞏 No 🞏 Client Doesn’t Know 🞏 Client Refused |
| **If Yes, when experience occurred:** | 🞏 Within the past three months 🞏 3-6 months ago 🞏 from 6 to 12 months ago 🞏 more than a year ago  🞏 Client Doesn’t Know 🞏 Client Refused |
| **(If Yes) Are you currently fleeing?** | 🞏 Yes 🞏 No 🞏 Client Doesn’t Know 🞏 Client Refused  |

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| --- | --- | --- |
| **Primary Reasons of Homelessness** | 🞏 Aged out of foster care🞏 Ask to leave by landlord🞏 Court eviction by landlord🞏 Domestic Violence🞏 Doubled-up/over crowded🞏 Eviction by primary tenant🞏 Fire or Natural Disaster🞏 Health/Safety Violation🞏 Household Disputes (not DV)🞏 Loss of Job/income (includes public benefits) | 🞏 Medical Condition🞏 Mental Health🞏 Mortgage foreclosure on rental property lived in🞏 Mortgage Foreclosure of own home🞏 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞏 Problems with building🞏 Problem with landlord🞏 Release from institution🞏 Relocation from out of Erie/Niagara area🞏 Substance Abuse🞏 Utility shutoff/arrears |
| **Zip Code** **of Last Permanent Residence** |  |  |
| **Housing Move-in Date****(RRH & PSH ONLY)** | \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ MM DD YYYY |  |

**4. Date Exit Elements**

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| Project exit date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **Reason for Leaving** | 🞏 Left for a housing opportunity before completing project🞏 Completed project🞏 Non-payment of rent/occupancy charge🞏 Non-compliance with project🞏 Criminal activity/destruction of property/ violence🞏 Reached maximum time allowed by project | 🞏 Needs could not be met by project🞏 Disagreement with rules/persons🞏 Death🞏 Unknown/disappeared🞏 Other |

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| **Destination** | 🞏 Place not meant for habitation (e.g., a vehicle, abandoned building, bus/train/subway station or anywhere outside)🞏 Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home Shelter🞏 Safe Haven 🞏 Foster care of 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🞏Residential project or halfway house with no homeless criteria 🞏Hotel or motel paid for without emergency shelter voucher 🞏Transitional housing for homeless persons (including youth)🞏Host Home (non-crisis) Client Refused | 🞏 Staying or living with family, temporary tenure🞏 Staying or living with friends, temporary tenure🞏 Staying or living with family, permanent tenure🞏 Staying or living with friends, permanent tenure🞏Moved from one HOPWA funded project to HOPWA PH🞏Moved from one HOPWA funded project to HOPWA TH🞏Rental by client, with GPD TIP 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🞏Rental by client in public housing unit🞏Rental by client, no ongoing housing subsidy 🞏Rental by client, with other ongoing subsidy 🞏Owned by client, no ongoing housing subsidy 🞏Owned by client, with ongoing housing subsidy🞏 No exit Interview completed🞏Other🞏Deceased🞏 Client Doesn’t KnowData not collected |

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| MONTHLY INCOME AT EXIT (Dependent Income recorded under Head of Household in HMIS) |
| **Income received From Any Source**Yes No Client Doesn’t Know Client RefusedIf yes, Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_(Needed For Each Income Source)**Total Monthly Income** $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Source of Income**Earned Income $\_\_\_\_\_\_\_\_\_Unemployment Insurance $\_\_\_\_\_\_\_\_\_Supplemental Security Income (SSI):$\_\_\_\_\_\_\_\_\_Social Security Disability Income (SSDI):$\_\_\_\_\_\_\_\_\_VA Service-Connected Disability Pension $\_\_\_\_\_\_\_\_\_Private Disability Insurance $\_\_\_\_\_\_\_\_\_Worker’s Compensation $\_\_\_\_\_\_\_\_\_Temporary Assistance for Needy Families (TANF):$\_\_\_\_\_\_\_\_\_ | General Assistance (GA) $\_\_\_\_\_\_\_\_\_Retirement from Social Security $\_\_\_\_\_\_\_\_\_Veteran’s Non-Service-Connected Disability Pension $\_\_\_\_\_\_\_\_Pension or Retirement from Former Job $\_\_\_\_\_\_\_\_Child Support $\_\_\_\_\_\_\_\_Alimony/Other Spousal Support $\_\_\_\_\_\_\_\_Other Sources: If Other: Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_$\_\_\_\_\_\_\_\_ |

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| NON-CASH BENEFITS AT EXIT(Dependent Income recorded under Head of Household in HMIS) |
| **Non-Cash Benefits From any source**Yes No Client Doesn’t Know Client RefusedIf yes, Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Source of Non-Cash Benefit**Food Stamps- Supplemental Nutrition Assistance Program Special Supplemental Nutrition Program for WICTANF Child Care ServicesTANF Transportation Services | Other TANF-Funded ServicesSection 8, Public Housing or rental assistanceOther Source \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Temporary rental assistance |
| HEALTH INSURANCE AT EXIT |
| **Covered By Health Insurance?**Yes No Client Doesn’t Know Client RefusedStart Date: \_\_\_\_\_\_\_\_\_\_\_\_\_End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Source of Non-Cash Benefit**Medicaid MedicareState Children’s Health Insurance ProgramVeteran’s (VA) Medical Services | Employer-Provided Health InsuranceHealth Insurance Obtained Through COBRAPrivate Pay Health InsuranceState Health Insurance For AdultsIndian Health Services Program |

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| **Disability Information At Exit** |
| **Long term Disabling Condition**Yes No Client Doesn’t Know Client Refused |
| **Disability Determination** Yes No Client Doesn’t Know Client Refused |
| **Disability Type:**  | Is the disability expected to be of long, continued, indefinite duration and substantially impairs the client’s ability to live independently? | Start Date |
| Physical Disability | Yes No Client Doesn’t Know Client Refused |  |
| Developmental Disability | Yes No Client Doesn’t Know Client Refused |  |
| Substance Abuse | Yes No Client Doesn’t Know Client Refused |  |
| Chronic Health Condition | Yes No Client Doesn’t Know Client Refused |  |
| Mental Health | Yes No Client Doesn’t Know Client Refused |  |
| HIV/AIDS  | Yes No Client Doesn’t Know Client Refused |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes No Client Doesn’t Know Client Refused |  |
| Notes: |