



1. Intake Summary

Project Name _____

Client ID (Computer Generated) _____

Project Start Date ____/____/____

Intake Staff Name _____

Housing Move-In Date ____/____/____

Preferred Language: _____

2. Client Demographics

First _____

Middle _____

Last _____

Suffix _____

Name Data Quality:

- Full name reported
- Client Doesn't Know

- Partial, street name, or code name reported
- Client Refused
- Data Not Collected

SSN/Code:	Date of Birth/Code:	Ethnicity:	Race:
_____ - ____ - _____ <input type="checkbox"/> Full SSN <input type="checkbox"/> Approx/Partial SSN <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	____/____/____ <input type="checkbox"/> Full DOB <input type="checkbox"/> Approx/Partial DOB <i>*At a minimum, approximate year of birth is required.</i>	<input type="checkbox"/> Non-Hispanic/Non-Latin(a)(o)(x) <input type="checkbox"/> Hispanic/Latin(a)(o)(x) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<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 <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
Gender (select all that apply)	Disabling Condition	Veteran Status	Relation to Head of Household
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> A gender that is not singularly 'Female' or 'Male' <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Self (head of household) <input type="checkbox"/> Head of household's child <input type="checkbox"/> Head of household's spouse/partner <input type="checkbox"/> Head of household's other relation member (other relation to head of household) <input type="checkbox"/> Other: non-relation member

3. Living Situation Prior to Entry

****ONLY ONE CHOICE** from either A, B, or C**

A. Homeless Situation: If client was homeless the night before entry, select one from here

- Place not meant for habitation (vehicle, streets, parks, abandoned buildings, or anywhere outside)
- Emergency shelter (including hotel/motel paid for with ES voucher or RHY-funded Host Home shelter)
- Safe Haven



B. Institutional Situation:

- | | |
|---|---|
| <input type="checkbox"/> Foster care home or foster care group home | <input type="checkbox"/> Long-term care facility or nursing home |
| <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility | <input type="checkbox"/> Psychiatric hospital or other psychiatric facility |
| <input type="checkbox"/> Jail, prison, or juvenile detention facility | <input type="checkbox"/> Substance abuse treatment facility/detox |

C. Transitional & Permanent Housing Situation:

- | | |
|---|---|
| <input type="checkbox"/> Host Home (non-crisis) | <input type="checkbox"/> Rental by client, with RRH or equivalent housing subsidy |
| <input type="checkbox"/> Hotel or motel paid without emergency shelter voucher | <input type="checkbox"/> Rental by client, with VASH housing subsidy |
| <input type="checkbox"/> Owned by client, no ongoing housing subsidy | <input type="checkbox"/> Residential project or halfway house with no homeless criteria |
| <input type="checkbox"/> Owned by client, with ongoing housing subsidy | <input type="checkbox"/> Staying in family member's apartment/house |
| <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless | <input type="checkbox"/> Staying in friend's room/apartment/house |
| <input type="checkbox"/> Rental by client in a public housing unit | <input type="checkbox"/> Transitional housing for homeless persons (including TAY) |
| <input type="checkbox"/> Rental by client, no ongoing housing subsidy | <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Rental by client, with GPD TIP subsidy | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based) | <input type="checkbox"/> Data not collected |
| <input type="checkbox"/> Rental by client, with other ongoing subsidy | |

4. Length of Stay

A. Length of Stay in Prior Living Situation:

- | | | |
|--|---|--|
| <input type="checkbox"/> One night or less | <input type="checkbox"/> One month or more, but less than 90 days | <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Two to six nights | <input type="checkbox"/> 90 days or more, but less than one year | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> One week or more, but less than one month | <input type="checkbox"/> One year or longer | <input type="checkbox"/> Data Not Collected |

**B. [For Institutional Situations <90 days or TH/PH < 7 nights only]
On the night before, did you stay on the streets, ES or SH?**

- No Yes

C. [For Homeless Situations, Institutional Situations <90 days or TH/PH < 7 nights only]

Approximate Date Homelessness Started	Regardless of where they stayed last night, # of Times Client has Been Homeless on the Streets, in ES, or SH in the Past Three Years Including Today	# of Months Homeless on the Streets, ES, or SH in Past Three Years
____/____/____	<input type="checkbox"/> One Time <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Two Times <input type="checkbox"/> Client Refused <input type="checkbox"/> Three Times <input type="checkbox"/> Data Not Collected <input type="checkbox"/> Four or More Times	<input type="checkbox"/> One Month (this is the first month) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> 2-12 Months (#____) <input type="checkbox"/> Data Not Collected <input type="checkbox"/> More Than 12 Months

5. Program Specific Information

Covered by Health Insurance	If Yes, Which Source(s)	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Medicaid (Medi-Cal) <input type="checkbox"/> Medicare <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> VA Medical Services (Military Insurance) <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 _____



Physical Disability		<i>If yes, expected to be of long-continued an indefinite duration and substantially impairs ability to live independently</i>		
<input type="checkbox"/> No	<input type="checkbox"/> Client Refused	<input type="checkbox"/> No	<input type="checkbox"/> Client Refused	
<input type="checkbox"/> Yes	<input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes	<input type="checkbox"/> Data Not Collected	
<input type="checkbox"/> Client Doesn't Know		<input type="checkbox"/> Client Doesn't Know		
Chronic Health Condition		<i>If yes, expected to be of long-continued an indefinite duration and substantially impairs ability to live independently</i>		
<input type="checkbox"/> No	<input type="checkbox"/> Client Refused	<input type="checkbox"/> No	<input type="checkbox"/> Client Refused	
<input type="checkbox"/> Yes	<input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes	<input type="checkbox"/> Data Not Collected	
<input type="checkbox"/> Client Doesn't Know		<input type="checkbox"/> Client Doesn't Know		
Mental Health Disorder		<i>If yes, expected to be of long-continued an indefinite duration and substantially impairs ability to live independently</i>		
<input type="checkbox"/> No	<input type="checkbox"/> Client Refused	<input type="checkbox"/> No	<input type="checkbox"/> Client Refused	
<input type="checkbox"/> Yes	<input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes	<input type="checkbox"/> Data Not Collected	
<input type="checkbox"/> Client Doesn't Know		<input type="checkbox"/> Client Doesn't Know		
Substance Use Disorder		<i>If yes, expected to be of long-continued an indefinite duration and substantially impairs ability to live independently</i>		
<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> No	<input type="checkbox"/> Client Refused	
<input type="checkbox"/> Alcohol Use Disorder	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes	<input type="checkbox"/> Data Not Collected	
<input type="checkbox"/> Drug Use Disorder	<input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Client Doesn't Know		
<input type="checkbox"/> Alcohol & Drug Use Disorders				
Developmental Disabilities				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
HIV/AIDS				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected

Domestic Violence Victim/Survivor	<i>If Yes, When Experience Occurred</i>		<i>If Yes, Are you Currently Fleeing</i>
<input type="checkbox"/> No	<input type="checkbox"/> Within the past three months	<input type="checkbox"/> One year ago or more	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> Three to six months ago	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Yes
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Six months to one year ago	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> Client Refused		<input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Client Refused
<input type="checkbox"/> Data Not Collected			<input type="checkbox"/> Data Not Collected



<p>Income From Any Source</p>	<p><i>If Yes, Indicate All Sources and Dollar Amounts that Apply</i></p>
<p> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected </p>	<p> _____ Earned Income _____ Unemployment Insurance _____ SSI _____ SSDI _____ VA Service-Connected Disability Compensation _____ VA Non-Service-Connected Disability Compensation _____ Private Disability Insurance _____ Worker's Compensation _____ TANF _____ General Assistance _____ Retirement Income from Social Security _____ Pension or Retirement from a Former Job _____ Child Support _____ Alimony or Other Spousal Support _____ Other Source _____ </p>
<p>Non-Cash Benefits from Any Source</p>	<p><i>If Yes, Indicate All Sources and Dollar Amounts that Apply</i></p>
<p> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected </p>	<p> _____ Supplemental Nutritional Assistance Program (Food Stamps) _____ Special Supplementation Nutritional Program for WIC _____ TANF Child Care Services _____ TANF Transportation Services _____ Other TANF-Funded Services _____ Other Source _____ </p>