



**1. Intake Summary**

**Project Name** \_\_\_\_\_ **Client ID** (Computer Generated) \_\_\_\_\_

**Project Start Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Housing Move-In Date** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Intake Staff Name** \_\_\_\_\_

**2. Client Demographics**

**First** \_\_\_\_\_ **Middle** \_\_\_\_\_ **Last** \_\_\_\_\_ **Suffix** \_\_\_\_\_

**Name Data Quality:**  Full name reported  Partial, street name, or code name reported  
 Client Doesn't Know  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

**Client Self-Reported Sexual Orientation and/or Gender Transition**

Gender (select all that apply)	Sex Listed on Birth Certificate:	Sexual Orientation:
<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"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Decline to State	<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Gay/Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Queer <input type="checkbox"/> Another Sexual Orientation  <input type="checkbox"/> Other <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected



<b>Disabling Condition:</b>	<b>Veteran Status:</b>	<b>Relation to Head of Household:</b>
<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**

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

**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

<b>C. [For Homeless Situations, Institutional Situations &lt;90 days or TH/PH &lt; 7 nights only]</b>		
<b>Approximate Date Homelessness Started</b>	<i>Regardless of where they stayed last night, <b># of Times Client has Been Homeless on the Streets, in ES, or SH in the Past Three Years Including Today</b></i>	<b># of Months Homeless on the Streets, ES, or SH in Past Three Years</b>
____/____/____	<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"/> 2-12 Months (#_____) <input type="checkbox"/> Client Refused <input type="checkbox"/> More Than 12 Months <input type="checkbox"/> Data Not Collected
<b>Covered by Health Insurance</b>	<i>If Yes, Which Source(s)</i>	
<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"/> Health Insurance obtained through COBRA <input type="checkbox"/> Medicare <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> VA Medical Services (Military Insurance) <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Other _____	

**5. Program Specific Information**

<b>In Temp Housing</b>	<b>HDAP Sub-Population</b> <i>(select all that apply)</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> GA/GR <input type="checkbox"/> Diverted from Jail/Prison <input type="checkbox"/> CalWORKs <input type="checkbox"/> Discharged from Institution <input type="checkbox"/> Low Income Vet <input type="checkbox"/> Other Low / No Income	
<b>Physical Disability</b>	<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"/> Yes <input type="checkbox"/> Data Not Collected <input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected <input type="checkbox"/> Client Doesn't Know	
<b>Chronic Health Condition</b>	<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"/> Yes <input type="checkbox"/> Data Not Collected <input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected <input type="checkbox"/> Client Doesn't Know	
<b>Mental Health Disorder</b>	<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"/> Yes <input type="checkbox"/> Data Not Collected <input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected <input type="checkbox"/> Client Doesn't Know	



<b>Substance Use Disorder</b>		<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			

<b>Developmental Disabilities</b>				
<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

<b>HIV/AIDS</b>				
<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

<b>Income From Any Source</b>	<i>If Yes, Indicate All Sources and Dollar Amounts that Apply</i>
<input type="checkbox"/> No	_____ Earned Income
<input type="checkbox"/> Yes	_____ Unemployment Insurance
<input type="checkbox"/> Client Doesn't Know	_____ SSI
<input type="checkbox"/> Client Refused	_____ SSDI
<input type="checkbox"/> Data Not Collected	_____ 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 _____

<b>Non-Cash Benefits from Any Source</b>	<i>If Yes, Indicate All Sources and Dollar Amounts that Apply</i>
<input type="checkbox"/> No	_____ Supplemental Nutritional Assistance Program (Food Stamps)
<input type="checkbox"/> Yes	_____ Special Supplementation Nutritional Program for WIC
<input type="checkbox"/> Client Doesn't Know	_____ TANF Child Care Services
<input type="checkbox"/> Client Refused	_____ TANF Transportation Services
<input type="checkbox"/> Data Not Collected	_____ Other TANF-Funded Services
	_____ Other Source _____