

1. Intake Summary

Project Name _____ **Client ID** (Computer Generated) _____

Project Start 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
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
****SELECT ONLY ONE** from either Homeless, Institutional, or TH & PH Situation**

Homeless

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

Institutional	<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
TH & PH	<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 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. On the night before, did you stay on the streets, ES or SH?

No Yes

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	<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"/> 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 _____