

## 1. Intake Summary

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

**Project Start Date** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Intake Staff Name** \_\_\_\_\_

## 2. Client Demographics

**First** \_\_\_\_\_ **Last** \_\_\_\_\_ **Suffix** \_\_\_\_\_ **DoB** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Parent:**       No       Yes       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**

<b>Homeless</b>	<input type="checkbox"/> Place not meant for habitation (vehicle, streets, parks, abandoned buildings, or anywhere outside) <input type="checkbox"/> Emergency shelter (including hotel/motel paid for with ES voucher) <input type="checkbox"/> Safe Haven
<b>Institutional</b>	<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison, or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility/detox

<b>TH &amp; PH</b>	<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. [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                     
  Client Doesn't Know                     
  Client Refused                     
  Data Not Collected

**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 _____

<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"/> 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		
<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"/> 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		
<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"/> 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		
<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>Addiction Type</b>				
<input type="checkbox"/> Alcohol		<input type="checkbox"/> Prescription		
<input type="checkbox"/> Meth		<input type="checkbox"/> Other: _____		
<input type="checkbox"/> Marijuana				
<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 <input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	_____ 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 _____					
<b>Non-Cash Benefits from Any Source</b>		<i>If Yes, Indicate All Sources and Dollar Amounts that Apply</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	_____ 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 _____					
<b>Convicted of Felony</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"/> Against Persons:	<input type="checkbox"/> Against Property:	<input type="checkbox"/> Drugs:	<input type="checkbox"/> Morals/Decency:	<input type="checkbox"/> Public Order:		
<input type="checkbox"/> Assault <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Homicide <input type="checkbox"/> Kidnapping <input type="checkbox"/> Robbery <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Other – against persons	<input type="checkbox"/> Arson <input type="checkbox"/> Burglary <input type="checkbox"/> Fraud/Forgery <input type="checkbox"/> Larceny <input type="checkbox"/> Trespassing <input type="checkbox"/> Vehicle Theft <input type="checkbox"/> Other – against property	<input type="checkbox"/> Possession <input type="checkbox"/> Sale <input type="checkbox"/> Other – drugs	<input type="checkbox"/> Gambling <input type="checkbox"/> Obscenity <input type="checkbox"/> Prostitution <input type="checkbox"/> Sex Offense <input type="checkbox"/> Other – morals/decency	<input type="checkbox"/> Criminal Nuisance <input type="checkbox"/> Disorderly Conduct <input type="checkbox"/> DUI/DWI <input type="checkbox"/> Harassment <input type="checkbox"/> Loitering <input type="checkbox"/> Weapons/Firearms <input type="checkbox"/> Other – public order		
<b>Probation</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>Sex Offender</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes				