

1. Intake Summary

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

Project Start Date ____/____/____

Intake Staff Name _____

Date of Engagement ____/____/____

2. Client Demographics

First _____ **Last** _____ **Suffix** _____ **DOB** ____/____/____

Parent: No Yes Client Doesn't Know Client Refused Data Not Collected

3. Living Situation Prior to Entry

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

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

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 Client Doesn't Know Client Refused Data Not Collected

Approximate Date Homelessness Started	<i>Regardless of where they stayed last night,</i> # 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"/> 2-12 Months (#_____) <input type="checkbox"/> Client Refused <input type="checkbox"/> More Than 12 Months <input type="checkbox"/> Data Not Collected

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 _____