



## Household Information

### Relationship to Head of Household

- Self (Head of Household)
- Head of household's child  Head of household's other relation member (other relation to head of household)
- Head of household's spouse or partner  Other: non-relation member

Client Location (CoC Code): OH-503

## Homeless Information-Type of Living Situation

### Residence Prior to Project Entry (HoH & adults)

#### Homeless Situation:

- Place not meant for habitation  Emergency Shelter
- Safe Haven

#### Institutional Situation:

- Foster care home or foster care group home  Hospital or other residential non-psychiatric medical facility
- Jail, prison, or juvenile detention facility  Long-term care facility or nursing home
- Psychiatric hospital or other psychiatric facility  Substance abuse treatment facility or detox center

#### Transitional and Permanent Housing Situation:

- Hotel or motel paid for without emergency shelter voucher  Owned by client, no ongoing housing subsidy
- Owned by client, with ongoing housing subsidy  PH (other than RRH) for formerly homeless persons
- Rental by client, no ongoing housing subsidy  Rental by client, with VASH subsidy
- Rental by client, with GPD TIP subsidy  Rental by client, with other ongoing housing subsidy (including RRH)
- Residential project or halfway house with no homeless criteria  Staying or living in a family member's room, apartment, or house
- Staying or living in a friend's room, apartment, or house  Transitional Housing for homeless persons
- Client Doesn't Know  Client refused

If residence prior to program entry is an institution, please provide name of institution/facility:

### Length of Stay in Previous Place

- One night or less (HUD)  One year or longer (HUD)
- Two to six nights (HUD)  Client doesn't know (HUD)
- One week or more but less than one month (HUD)  Client refused (HUD)
- One month or more, but less than 90 days (HUD)
- 90 days or more but less than one year (HUD)

### Approximate Date Homelessness Started: \_\_\_\_\_

Regardless of where they stayed last night- Number of Times the Client has been Homeless on the streets\*, in ES, or SH in the Past Three years including today (HoH & Adults)

- Never in the past 3 years
- One time (homeless only this time)
- Two times  Client doesn't know
- Three times  Client refused
- Four or more times  Data not collected

Total number of months homeless on the street, in ES, or SH in the past three years†

- One month (this time is the first time)
- If 2-12, Specify #: \_\_\_\_\_
- More than 12 months
- Client doesn't know
- Client refused

**Disabling Conditions (all clients)**

Does the client have a disabling condition?

- No     Yes     Client doesn't know     Client refused

**Physical**

Long term?

- |  |                              |  |                              |
|--|------------------------------|--|------------------------------|
| <input type="checkbox"/> No                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                  | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Client doesn't know |                              | <input type="checkbox"/> Client doesn't know |                              |
| <input type="checkbox"/> Client refused      |                              | <input type="checkbox"/> Client refused      |                              |

**Developmental**

- No     Yes
- Client doesn't know
- Client refused

**Chronic Health**

Long term?

- |  |                              |  |                              |
|--|------------------------------|--|------------------------------|
| <input type="checkbox"/> No                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                  | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Client doesn't know |                              | <input type="checkbox"/> Client doesn't know |                              |
| <input type="checkbox"/> Client refused      |                              | <input type="checkbox"/> Client refused      |                              |

**HIV**

- No     Yes
- Client doesn't know
- Client refused

**Mental Health**

Long term?

- |  |                              |  |                              |
|--|------------------------------|--|------------------------------|
| <input type="checkbox"/> No                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                  | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Client doesn't know |                              | <input type="checkbox"/> Client doesn't know |                              |
| <input type="checkbox"/> Client refused      |                              | <input type="checkbox"/> Client refused      |                              |

**Alcohol Use Disorder**

Long term?

- |  |                              |  |                              |
|--|------------------------------|--|------------------------------|
| <input type="checkbox"/> No                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                  | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Client doesn't know |                              | <input type="checkbox"/> Client doesn't know |                              |
| <input type="checkbox"/> Client refused      |                              | <input type="checkbox"/> Client refused      |                              |

**Drug Abuse**

Long term?

- |  |                              |  |                              |
|--|------------------------------|--|------------------------------|
| <input type="checkbox"/> No                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                  | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Client doesn't know |                              | <input type="checkbox"/> Client doesn't know |                              |
| <input type="checkbox"/> Client refused      |                              | <input type="checkbox"/> Client refused      |                              |

**Both Alcohol/Drug**

Long term?

- |  |                              |  |                              |
|--|------------------------------|--|------------------------------|
| <input type="checkbox"/> No                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                  | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Client doesn't know |                              | <input type="checkbox"/> Client doesn't know |                              |
| <input type="checkbox"/> Client refused      |                              | <input type="checkbox"/> Client refused      |                              |

### Domestic Violence (HoH & Adults)

Is client a domestic violence victim/survivor?

No  Yes

Client doesn't know

Client refused

If Yes, when did the experience occur?

Within the past three months

Three to six months ago

Six months to one year ago

One year or more

If yes, are you currently fleeing?

No  Client doesn't know

Yes  Client refused

Client doesn't know

Client refused

### Income

Income from Any Source (HoH & Adults (child-->HoH))

No  Yes

Client doesn't know  Client refused

Answer Yes or No for each income source (status at time of entry)

Source of Income	Receiving income?	If yes, monthly amount from source (round down to nearest dollar)	
Earned income (i.e., employment income)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Unemployment Insurance	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Supplemental Security Income (SSI)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Social Security Disability Income (SSDI)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
VA Service-Connected Disability	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
VA Non-Service-Connected Disability Pension	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Private disability insurance	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Worker's Compensation	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Temporary Assistance for Needy Families (TANF)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
General Assistance (GA)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Retirement Income from Social Security	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Pension or retirement income from a former job	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Child support	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Alimony or other spousal support	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Other Source	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
If yes, specify source:			

Total Monthly Income from all sources

\$

.00

## Non-Cash Benefits

Non-Cash Benefits from any source? (HoH & Adults (children go on HoH))

<input type="checkbox"/> Yes	<b>Answer 'Yes' or 'No' for each non-cash benefit source (Based on the status at the time of entry)</b>
<input type="checkbox"/> No	
<input type="checkbox"/> Client doesn't know	
<input type="checkbox"/> Client refused	
	<b>No Yes Source of non-cash benefit</b>
	<input type="checkbox"/> <input type="checkbox"/> Special Supplemental Nutrition Assistance Program (SNAP)
	<input type="checkbox"/> <input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
	<input type="checkbox"/> <input type="checkbox"/> TANF Child Care services
	<input type="checkbox"/> <input type="checkbox"/> TANF transportation services
	<input type="checkbox"/> <input type="checkbox"/> Other TANF-Funded Services
	<input type="checkbox"/> <input type="checkbox"/> Other source: _____

## Health Insurance

Covered by health insurance (all clients)

<input type="checkbox"/> Yes	<b>Answer 'Yes' or 'No' for each health insurance source. (Based on the status at the time of entry)</b>
<input type="checkbox"/> No	
<input type="checkbox"/> Client doesn't know	
<input type="checkbox"/> Client refused	
	<b>No Yes Source of insurance coverage</b>
	<input type="checkbox"/> <input type="checkbox"/> Medicaid
	<input type="checkbox"/> <input type="checkbox"/> Medicare
	<input type="checkbox"/> <input type="checkbox"/> State Children's Health Insurance Program
	<input type="checkbox"/> <input type="checkbox"/> Veteran's Administration (VA) Medical Services
	<input type="checkbox"/> <input type="checkbox"/> Employer-Provided Health Insurance
	<input type="checkbox"/> <input type="checkbox"/> Health insurance obtained through COBRA
	<input type="checkbox"/> <input type="checkbox"/> Private Pay Health Insurance
	<input type="checkbox"/> <input type="checkbox"/> State Health Insurance for Adults (or use local name)
	<input type="checkbox"/> <input type="checkbox"/> Indian Health Services Program
	<input type="checkbox"/> <input type="checkbox"/> Other source: _____