Assessment: Entry/Intake
Funder(s): HUD: CoC/ESG/ESG-RUSH/Unshelter Special NOFO/Rural Special NOFO
Project(s): Day Shelter, Homeless Prevention, Single Room Occupancy, Supportive Services Only, Transistional Housing
Applies To: Head of Household (Primary) & Adults (18+)

HOUSING FORWARD

Step 1: Client Demographics

All fields with an * are required

First & Last Name:* _____

Middle Name: _____ Alias: _____

Name Data Quality:*

☐ Full Name Reported
☐ Partial, Street, or Code Name Reported
☐ Client Doesn't Know
☐ Client Prefers Not to Answer
☐ Data Not Collected

Social Security Number:* _____ - _____ - _____

☐ Full SSN Reported
☐ Approximate or Partial SSN Reported
☐ Client Doesn't Know
☐ Client Prefers Not to Answer
☐ Data Not Collected

Birth Date:* MM / DD / YYYY

☐ Full DOB Reported
☐ Approximate or Partial DOB Reported
☐ Client Doesn't Know
☐ Client Prefers Not to Answer
☐ Data Not Collected

Race and Ethnicity:*

☐ American Indian, Alaska Native, or Indigenous
☐ Asian or Asian American
☐ Black, African American, or African
☐ Hispanic/Latina/o
☐ Middle Eastern or North African
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Client doesn't know
☐ Client prefers not to answer
☐ Data not collected
☐ Additional Race and Ethnicity Detail:

Sex:*

☐ Female
☐ Male
☐ Client doesn't know
☐ Client prefers not to answer
☐ Data not collected

Gender:

☐ Woman (Girl, if child)
☐ Man (Boy, if child)
☐ Culturally Specific Identity (e.g., Two-Spirit)
☐ Transgender
☐ Non-Binary
☐ Questioning
☐ Different Identity
☐ Client doesn't know
☐ Client prefers not to answer
☐ Data not collected
☐ If Different Identity, please specify:

Pregnancy Status:

☐ Yes
If Yes, Due Date:* MM / DD / YYYY
☐ No
☐ Client doesn't know
☐ Client prefers not to answer
☐ Data not collected

Veteran Status:*

☐ Yes
☐ No
☐ Client doesn't know
☐ Client prefers not to answer
☐ Data not collected

Contact Information

Address: _____ City/State/Zip: _____

Email: _____ Phone: _____

Relationship to Head of Household:*

☐ Self (Head of Household)
☐ Head of Household's Child
☐ Head of Household's Spouse or Partner
☐ Head of Household's Other Relation Member
☐ Other: Non-Relation Member

Step 2: Project Enrollment

Project Start Date:* MM / DD / YYYY

Case Manager: _____

Revised: September 2025

Step 3: Entry Assessments

Disabling Condition:*

☐ Yes ☐ Client doesn't know ☐ Data not collected
☐ No ☐ Client prefers not to answer

Prior Living Situation*

*Identify where the client slept the night before enrollment - **ONLY SELECT ONE***

Homeless Situations

☐ Place not meant for habitation (e.g., vehicle, abandoned building, bus/train/subway/station/airport, or anywhere outside)
☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher
☐ Safe Haven

Institutional Situations

☐ 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

Temporary Housing Situations

☐ Residential project or halfway house with no homeless criteria
☐ Transitional housing for homeless persons (including homeless youth)
☐ Hotel or motel paid for without emergency shelter voucher
☐ Host Home (non-crisis)
☐ Staying or living in a friend's room, apartment, or house
☐ Staying or living in a family member's room, apartment, or house

Permanent Housing situation

☐ Owned by client, with ongoing housing subsidy
☐ Owned by client, no ongoing housing subsidy
☐ Rental by client, with ongoing housing subsidy
☐ Rental by client, no ongoing housing subsidy

Other

☐ Client doesn't know
☐ Client prefers not to answer
☐ Data not collected

*If "Yes, Rental by Client, with Ongoing Housing Subsidy" – **Specify**:**

☐ GPD TIP housing subsidy
☐ VASH housing subsidy
☐ RRH or equivalent subsidy
☐ HCV voucher (tenant or project based) (not dedicated)
☐ Public housing unit
☐ Other permanent housing dedicated for formerly homeless persons
☐ Rental by client, with other ongoing housing subsidy
☐ Housing Stability Voucher
☐ Family Unification Program Voucher (FUP)
☐ Foster Youth to Independence Initiative (FYI)
☐ Permanent Supportive Housing

Length of stay in prior living situation:*

☐ One night or less
☐ Two to six nights
☐ One week or more, but less than one month
☐ One month or more, but less than 90 days
☐ 90 days or more, but less than one year
☐ Client doesn't know
☐ Client prefers not to answer
☐ Data not collected

FOR INSTITUTIONAL SITUATIONS

Did you stay less than 90 days: * ☐ Yes ☐ No

FOR TEMPORARY, PERMANENT, & OTHER SITUATIONS

Did you stay less than 7 nights: * ☐ Yes ☐ No

*If "Yes, Stayed in a Temporary, Permanent or Other Situation for less than 7 nights **OR** Stayed in an Institutional Situation for less than 90 days*

On the night before did you stay on the streets, ES, or SH:* ☐ Yes ☐ No

If "Yes, On the night before did you stay on the streets, ES, or SH" or if Prior Living Situation is a "Homeless Situation"

Approximate date this episode of homelessness started:* MM / DD / YYYY

Number of *times* the client has been on the streets, ES or Safe Haven in the last 3 years (including today):*

☐ One Time ☐ Three Times ☐ Client prefers not to answer ☐ Data not collected
☐ Two Times ☐ Four or More Times ☐ Client doesn't know

Revised: September 2025

Total number of months homeless on the streets, in ES, or SH in the past three years:*

- ☐ One month (this time is the first month)
- ☐ 2-12 months (specify number of months): _____
- ☐ More than 12 months
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Data not collected

Covered By Health Insurance*

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Data not collected

*If "Yes, Covered by Health Insurance" - Specify:**

- ☐ MEDICAID
- ☐ MEDICARE
- ☐ State Children's Health Insurance (S-CHIP)
- ☐ Veteran's Health Administration (VHA)
- ☐ Employer Provided Health Insurance
- ☐ Health Insurance Obtained Through COBRA
- ☐ Private Pay Health Insurance
- ☐ State Health Insurance for Adults
- ☐ Indian Health Services Program
- ☐ Other (specify):_____

Barriers (Disabling Conditions)

Physical Disability*

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Data not collected

*If "Yes, is it Expected to be of **Long-Continued & Indefinite Duration and Substantially Impair Ability to Live Independently**"**

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Data not collected

Developmental Disability*

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Data not collected

Chronic Health Condition*

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Data not collected

*If "Yes, is it Expected to be of **Long-Continued & Indefinite Duration and Substantially Impair Ability to Live Independently**"**

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Data not collected

HIV/AIDS*

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Data not collected

Mental Health Disorder*

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Data not collected

*If "Yes, is it Expected to be of **Long-Continued & Indefinite Duration and Substantially Impair Ability to Live Independently**"**

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Data not collected

Alcohol Use Disorder*

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Data not collected

*If "Yes, is it Expected to be of **Long-Continued & Indefinite Duration and Substantially Impair Ability to Live Independently**"**

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Data not collected

Drug Use Disorder*

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Data not collected

*If "Yes, is it Expected to be of **Long-Continued & Indefinite Duration and Substantially Impair Ability to Live Independently****

☐ Yes ☐ Client doesn't know ☐ Data not collected
☐ No ☐ Client prefers not to answer

Survivor of Domestic Violence*

☐ Yes ☐ Client doesn't know ☐ Data not collected
☐ No ☐ Client prefers not to answer

If "Yes, Survivor of Domestic Violence"

When experience occurred:*

☐ Within the past three months ☐ Client doesn't know
☐ Three to six months ago (excluding six months exactly) ☐ Client prefers not to answer
☐ Six months to one year ago (excluding one year exactly) ☐ Data not collected
☐ One year ago, or more

Are you currently fleeing?:*

☐ Yes ☐ Client doesn't know ☐ Data not collected
☐ No ☐ Client prefers not to answer

Income from Any Source*

☐ Yes ☐ Client doesn't know ☐ Data not collected
☐ No ☐ Client prefers not to answer

*If "Yes, Income from Any Source" – **Specify Type & Monthly Amount:****

☐ Earned Income Amount: $_____
☐ Unemployment Insurance Amount: $_____
☐ Supplemental Security Income (SSI) Amount: $_____
☐ Social Security Disability Insurance (SSDI) Amount: $_____
☐ VA Service-Connected Disability Compensation Amount: $_____
☐ VA Non-Service-Connected Disability Pension Amount: $_____
☐ Private disability insurance Amount: $_____
☐ Worker's Compensation Amount: $_____
☐ Temporary Assistance for Needy Families (TANF) Amount: $_____
☐ General Assistance (GA) Amount: $_____
☐ Retirement income from Social Security Amount: $_____
☐ Pension or retirement income from a former job Amount: $_____
☐ Child support Amount: $_____
☐ Alimony and other spousal support Amount: $_____
☐ Other income source *(specify):*_____ Amount: $_____

Non-Cash Benefits from Any Source*

☐ Yes ☐ Client doesn't know ☐ Data not collected
☐ No ☐ Client prefers not to answer

*If "Yes, Non-Cash from Any Source" – **Specify Type & Monthly Amount:****

☐ Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps) Amount: $_____
☐ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Amount: $_____
☐ TANF Child Care services Amount: $_____
☐ TANF transportation services Amount: $_____
☐ Other TANF-funded services Amount: $_____
☐ Other source *(specify):*_____ Amount: $_____

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