

Assessment: Entry/Intake
Funder(s): HUD: CoC/Unshelter Special NOFO/Rural Special NOFO
Project(s): Permanent Supportive Housing
Applies To: Accompanied Youth - Under 18



Step 1: Client Demographics

All fields with an * are required

First & Last Name:*

Middle Name:

Alias:

Name Data Quality:*

☐ Full Name Reported

☐ Client Doesn't Know

☐ Data Not Collected

☐ Partial, Street, or Code Name Reported

☐ Client Prefers Not to Answer

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:

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:

Sex:*

☐ Female

☐ Male

☐ Client doesn't know

☐ Client prefers not to answer

☐ Data not collected

Pregnancy Status:

☐ Yes

If Yes, Due Date:*

MM / DD / YYYY

☐ No

☐ Client doesn't know

☐ Client prefers not to answer

☐ Data not collected

Relationship to 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:

Step 3: Entry Assessments

Disabling Condition:*

☐ Yes

☐ No

☐ Client doesn't know

☐ Client prefers not to answer

☐ Data not collected

Assessment: Entry/Intake
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Covered By Health Insurance*

- | | | |
|------------------------------|---|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Data not collected |
| <input type="checkbox"/> No | <input type="checkbox"/> Client prefers not to answer | |

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

- | | |
|---|--|
| <input type="checkbox"/> MEDICAID | <input type="checkbox"/> Health Insurance Obtained Through COBRA |
| <input type="checkbox"/> MEDICARE | <input type="checkbox"/> Private Pay Health Insurance |
| <input type="checkbox"/> State Children's Health Insurance (S-CHIP) | <input type="checkbox"/> State Health Insurance for Adults |
| <input type="checkbox"/> Veteran's Health Administration (VHA) | <input type="checkbox"/> Indian Health Services Program |

Barriers (Disabling Conditions)

Physical Disability*

- | | | |
|------------------------------|---|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Data not collected |
| <input type="checkbox"/> No | <input type="checkbox"/> Client prefers not to answer | |

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

- | | | |
|------------------------------|---|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Data not collected |
| <input type="checkbox"/> No | <input type="checkbox"/> Client prefers not to answer | |

Developmental Disability*

- | | | |
|------------------------------|---|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Data not collected |
| <input type="checkbox"/> No | <input type="checkbox"/> Client prefers not to answer | |

Chronic Health Condition*

- | | | |
|------------------------------|---|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Data not collected |
| <input type="checkbox"/> No | <input type="checkbox"/> Client prefers not to answer | |

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

- | | | |
|------------------------------|---|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Data not collected |
| <input type="checkbox"/> No | <input type="checkbox"/> Client prefers not to answer | |

HIV/AIDS*

- | | | |
|------------------------------|---|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Data not collected |
| <input type="checkbox"/> No | <input type="checkbox"/> Client prefers not to answer | |

Mental Health Disorder*

- | | | |
|------------------------------|---|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Data not collected |
| <input type="checkbox"/> No | <input type="checkbox"/> Client prefers not to answer | |

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

- | | | |
|------------------------------|---|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Data not collected |
| <input type="checkbox"/> No | <input type="checkbox"/> Client prefers not to answer | |

Alcohol Use Disorder*

- | | | |
|------------------------------|---|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Data not collected |
| <input type="checkbox"/> No | <input type="checkbox"/> Client prefers not to answer | |

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

- | | | |
|------------------------------|---|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Data not collected |
| <input type="checkbox"/> No | <input type="checkbox"/> Client prefers not to answer | |

Drug Use Disorder*

- | | | |
|------------------------------|---|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Data not collected |
| <input type="checkbox"/> No | <input type="checkbox"/> Client prefers not to answer | |

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

- | | | |
|------------------------------|---|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Data not collected |
| <input type="checkbox"/> No | <input type="checkbox"/> Client prefers not to answer | |