

Assessment: Entry/Intake
Funder(s): HUD: HUD/VASH
Project(s): Collaborative Case Management (PH)
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:*

- | | | |
|---|---|---|
| <input type="checkbox"/> Full Name Reported | <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Data Not Collected |
| <input type="checkbox"/> Partial, Street, or Code Name Reported | <input type="checkbox"/> 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:*

- | | | |
|--|--|--|
| <input type="checkbox"/> American Indian, Alaska Native, or Indigenous | <input type="checkbox"/> Native Hawaiian or Pacific Islander | <input type="checkbox"/> Additional Race and Ethnicity Detail: |
| <input type="checkbox"/> Asian or Asian American | <input type="checkbox"/> White | |
| <input type="checkbox"/> Black, African American, or African | <input type="checkbox"/> Client doesn't know | |
| <input type="checkbox"/> Hispanic/Latina/o | <input type="checkbox"/> Client prefers not to answer | |
| <input type="checkbox"/> Middle Eastern or North African | <input type="checkbox"/> Data not collected | |

Gender:

- | | | |
|--|---|---|
| <input type="checkbox"/> Woman (Girl, if child) | <input type="checkbox"/> Questioning | <input type="checkbox"/> If Different Identity, Please Specify: |
| <input type="checkbox"/> Man (Boy, if child) | <input type="checkbox"/> Different Identity | |
| <input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit) | <input type="checkbox"/> Client doesn't know | |
| <input type="checkbox"/> Transgender | <input type="checkbox"/> Client prefers not to answer | |
| <input type="checkbox"/> Non-Binary | <input type="checkbox"/> Data not collected | |

Pregnancy Status:

- | | | |
|--|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Client prefers not to answer |
| If Yes, Due Date:* ____ MM / ____ DD / ____ YYYY | | <input type="checkbox"/> Client doesn't know |
| | | <input type="checkbox"/> Data not collected |

Relationship to Head of Household:*

- | | |
|--|--|
| <input type="checkbox"/> Head of Household's Child | <input type="checkbox"/> Head of Household's Other Relation Member |
| <input type="checkbox"/> Head of Household's Spouse or Partner | <input type="checkbox"/> Other: Non-Relation Member |

Step 2: Project Enrollment

Project Start Date:* ____ MM / ____ DD / ____ YYYY Case Manager: _____

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Step 3: Entry Assessments

Disabling 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	
Total number of months homeless on the streets, in ES, or SH in the past three years:*		
<input type="checkbox"/> One month (this time is the first month)	<input type="checkbox"/> Client doesn't know	
<input type="checkbox"/> 2-12 months (specify number of months): _____	<input type="checkbox"/> Client prefers not to answer	
<input type="checkbox"/> More than 12 months	<input type="checkbox"/> Data not collected	
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	
<i>If "Yes, Covered by Health Insurance" – Specify:*</i>		
<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	
<input type="checkbox"/> Employer Provided Health Insurance	<input type="checkbox"/> Other (specify): _____	