

Assessment: Entry/Intake
Funder(s): HUD: CoC - YHDP
Project(s): Joint Component TH/RRH, Permanent Supportive Housing, & Rapid Re-Housing
Applies To: Child of Parenting Youth



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:* ____/____/____

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

Sex:*

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

Gender:

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

Pregnancy Status:

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

Relationship to Head of Household:*

- ☐ Head of Household's Child

Step 2: Project Enrollment

Project Start Date:* ____/____/____ Case Manager: _____

Step 3: Entry Assessments

Disabling Condition:*

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

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Covered By Health Insurance*

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

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

- | | |
|---|--|
| ☐ MEDICAID | ☐ Health Insurance Obtained Through COBRA |
| ☐ MEDICARE | ☐ Private Pay Health Insurance |
| ☐ State Children's Health Insurance (S-CHIP) | ☐ State Health Insurance for Adults |
| ☐ Veteran's Health Administration (VHA) | ☐ Indian Health Services Program |

Barriers (Disabling Conditions)

Physical Disability*

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

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 | |

Developmental Disability*

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

Chronic Health Condition*

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

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 | |

HIV/AIDS*

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

Mental Health Disorder*

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

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 | |

Alcohol Use Disorder*

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

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 | |

Drug Use Disorder*

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

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 | |