

Assessment: Entry/Intake  
Funder(s): HUD: CoC - YHDP  
Project(s): Supportive Services Only  
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

**Assessment:** Entry/Intake  
**Funder(s):** HUD: CoC - YHDP  
**Project(s):** Supportive Services Only  
**Applies To:** Child of Parenting Youth



### 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 |   |