Date____________________ PSH and RRH Programs HMIS ID#_____________________

CoC Program Entry-Intake Form

*To be completed on all **ADULTS** over the age of 18 in the household.*

Personal Information

Name:___________________________________ Date of Birth____________ Veteran?_________

SSN:_____________________________________

What is your Primary Race?

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/ Pacific Islander
- ☐ White

Which Ethnicity do you most identify with?

- ☐ Non-Hispanic/Non-Latino
- ☐ Hispanic/Latino
- ☐ Don't know
- ☐ Refused

Which Gender do you identify as?

- ☐ Female
- ☐ Male
- ☐ Transgender
- ☐ Questioning
- ☐ Non Binary/Fluid/Agender
- ☐ I don't know
- ☐ Refused

Relationship to the Head of Household (HOH)

- ☐ Self (HOH)
- ☐ HOH's Child
- ☐ HOH's spouse or partner
- ☐ HOH's other relation member
- ☐ Other Non related

Disability Information

Do you have a disabling condition like a physical, mental, emotional, developmental, HIV/AIDS, or substance use disorder that significantly impairs your ability to perform daily activities?

☐ Yes ☐ No

If yes, what kind of Disability Condition do you have? (Select All that apply)

- ☐ Alcohol Use Disorder
- ☐ Alcohol & Drug Use Disorder
- ☐ Chronic Health Condition
- ☐ Developmental
- ☐ Drug Use Disorder
- ☐ HIV\AIDS
- ☐ Mental Health Disorder
- ☐ Physical

Has a medical provider ever diagnosed the disability? (Disability Determination)

☐ Yes ☐ No

Does the condition significantly impair your daily living and ability to keep a steady job or housing (Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?)

☐ Yes ☐ No ☐ Don't know

Health Insurance

Do you have health insurance?

☐ Yes ☐ No ☐ Don't know

If yes, what type(s) of Health Insurance (select all that apply):

- ☐ Medicaid **– What Medicaid plan**: ______________________________
- ☐ Medicare
- ☐ State Children's Health Ins
- ☐ (VA) Medical Services
- ☐ Employer Provided Health Ins
- ☐ Health Ins Obtained via Cobra
- ☐ Private Pay Health Ins
- ☐ State Health Ins for Adults
- ☐ Indian Health Services Program
- ☐ Other

Prior Living Situation

Where did you sleep last night? (Prior Living Situation): ____

How long have you been in the above living situation? (Length of stay in previous place)

- ☐ 1 night or less
- ☐ 2 – 6 nights
- ☐ 7+ night-less than a month
- ☐ 1 month – 89 days
- ☐ 90+ days-less than a year
- ☐ 1 year or longer

What's the approximate date your current homeless episode began: ___________/______/________

Regardless of where you stayed last night, how many times have you been homeless on streets or shelters in the last 3 years?

- ☐ 1 time (use for 1 long consecutive episode)
- ☐ 2 times
- ☐ 3 times
- ☐ 4 of more times

What's the total number of months you've been homeless on the streets/shelters in the past 3 years: ___________

What county were you in when this current episode of homelessness began?

- ☐ Orange
- ☐ Seminole
- ☐ Osceola
- ☐ Other_____________________

What is the last known address where you have stayed? (Residence or Last Permanent Address)

- Street Address: ____Unit Number: ____________
- City, ST, Zip Code:____
- Start Date _______________ End Date:_________________________

Domestic Violence

If you feel comfortable sharing, have you ever experienced intimate partner violence or domestic violence?

- ☐ Yes
- ☐ No

If yes, when did the last experience occur?

- ☐ Within the past three months
- ☐ Three to six months ago
- ☐ Six to twelve months ago
- ☐ More than a year ago

Are you currently trying to get out of a dangerous situation?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

Income

Do you have income from any source in the last 30 days?

- ☐ Yes
- ☐ No
- ☐ I don't know

If yes to any of the following income, specify *gross* amount:

- ☐ Alimony/Spousal Support _______
- ☐ Child Support _______
- ☐ Earned Income _______
- ☐ General Assistance _______
- ☐ Other _______
- ☐ Pension or retirement from job _______
- ☐ Private Disability _______
- ☐ Retirement from SSA _______
- ☐ SSDI _______
- ☐ SSI _______
- ☐ TANF _______
- ☐ Unemployment _______
- ☐ VA Non Service Connected Disb. _______
- ☐ VA Service Connected Disability _______
- ☐ Worker's Comp _______

Total Monthly Income: $________________________

Non Cash Benefits

2. Do you have any Non-Cash benefit from any source?

☐ Yes ☐ No ☐ I don't know

If yes to Non-Cash benefits, specify amount:

☐ SNAP ____________
☐ WIC ____________
☐ TANF Child Care ____________
☐ TANF Transportation ______________
☐ Other TANF-funded Services: ______________
☐ Other Source ______________

Employment

Are you employed? Y / N

If yes, Type of Employment: ☐ Full Time ☐ Part Time ☐ Seasonal/Sporadic (including day labor

If No*,* Reason: ☐ Looking for work ☐ Unable to work ☐ Not looking for work

If you have severe and persistent disability, do you need help applying for SSI (SOAR)? ☐ Yes ☐ No

Well Being

How strongly do you agree or disagree with the following statements?

I feel my life has value and worth.

☐ Strongly Disagree
☐ Somewhat disagree
☐ Neither agree or disagree
☐ Somewhat agree
☐ Strongly agree
☐ I don't know
☐ Refused

I can bounce back after hard times.

☐ Strongly Disagree
☐ Somewhat disagree
☐ Neither agree or disagree
☐ Somewhat agree
☐ Strongly agree
☐ I don't know
☐ Refused

I have support from others who will listen to my problems.

☐ Strongly Disagree
☐ Somewhat disagree
☐ Neither agree or disagree
☐ Somewhat agree
☐ Strongly agree
☐ I don't know
☐ Refused

I feel nervous, tense, worried, frustrated or afraid.

☐ Not at all
☐ Once a month
☐ Several times a month
☐ Several times a week
☐ At least every day
☐ I don't know
☐ Refused

Contact Info

Phone Number: ____

Email: ____

Emergency Contacts

Contact 1: ______________________________ _______________ _______________________________

Name Relationship How to contact

Contact 1: ______________________________ _______________ _______________________________

Name Relationship How to contact