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:_____ Phone:_____

Email:_____Emergency Contact Info:_____

What is your Primary Race?

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

Which Ethnicity do you most identify with?

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

Which Gender do you identify as?

☐ Female ☐ Trans Female (MTF) ☐ I don't know
☐ Male ☐ Trans Male (FTM) ☐ Refused
☐ Gender Non-Conforming

Relationship to the Head of Household

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

CoC Location

☐ Orange, Seminole, Osceola (FL-507) ☐ Citrus, Hernando, Lake, Sumter (FL-520)

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

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 ☐ I don't know ☐ Don't know

Health Insurance

☐ Yes ☐ No ☐ Don't know

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

☐ Medicaid ☐ Indian Health Services Program ☐ State Health Ins for Adults
☐ Medicare ☐ State Children's Health Ins ☐ Other
☐ Employer Provided Health Ins ☐ (VA) Medical Services **Medicaid plan, if applicable**:
☐ Health Ins Obtained via Cobra ☐ Private Pay Health Ins _____

Prior Living Situation

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

- ☐ Streets / Place not meant for habitation
- ☐ Emergency Shelter (ES), including hotel or motel paid for with emergency voucher
- ☐ Safe Haven (Emergency Shelter for persons with severe mental illness)

- ☐ Foster care home or foster care group home
- ☐ Hospital or other residential non-psychiatric medical facility
- ☐ Jail, prison or juvenile detention facility
- ☐ Long-term care facility or nursing home
- ☐ Psychiatric hospital or other psychiatric facility
- ☐ Substance abuse treatment facility or detox center

- ☐ Residential project or halfway house with no homeless criteria
- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Transitional housing for homeless persons (including homeless youth)
- ☐ Host Home (non Crisis)
- ☐ Staying or living in a family member's room, apartment or house
- ☐ Staying or living in a friend's room, apartment or house
- ☐ Rental by client, with GPD TIP subsidy
- ☐ Rental by client, with VASH subsidy
- ☐ Permanent housing (Other than RRH) for formerly homeless persons
- ☐ Rental by client, with RRH or equivalent subsidy
- ☐ Rental by client, with HCV (tenant or project based)
- ☐ Rental by client in a public housing unit
- ☐ Rental by client, no ongoing housing subsidy
- ☐ Rental by client, with other ongoing housing subsidy
- ☐ Owned by client, with ongoing housing subsidy
- ☐ Owned by client, no ongoing housing subsidy

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 ES 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/ES in the past 3 years: _____

CoC Questions

What county were you in when this 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:_____
- State: _____
- Zip:_____
- Start Date:_____/_____/_____ End Date:_____/_____/_____

Domestic Violence

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

- ⌋ Yes
- ⌋ No
- ⌋ I don't know
- ⌋ Refused

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
- ⌋ I don't know
- ⌋ Refused

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

- ⌋ Yes
- ⌋ No
- ⌋ Client Doesn't Know
- ⌋ Client 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

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

Case Notes: _____

_____

_____