

Agency's LOGO



Head of Household Name: _____

Universal Intake Form

Head of Household

HMIS CLIENT ID#

INTAKE/ENTRY DATE

--	--

FILL-IN AFTER SERVICEPOINT ENTRY

MONTH / DAY / YEAR

NAME OF HEAD OF HOUSEHOLD (first, middle, last name, suffix (e.g., Jr, Sr, III))

				Client doesn't know	Client refused
First Name		Middle Name		<input type="checkbox"/>	<input type="checkbox"/>
Last Name		Alias/Suffix		<input type="checkbox"/>	<input type="checkbox"/>
SSN			Approx. or Partial SSN Reported <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Veteran Status	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Veteran Status is on the Client Profile Tab and may need to be updated if the client is already in ServicePoint.</i>			<input type="checkbox"/>	<input type="checkbox"/>
Date of Birth			Approx. or Partial DOB Reported <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary Race	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> White		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>
Secondary Race (Leave Blank if None)	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> White		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other	NA	NA
Ethnicity	<input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Hispanic/Latino			<input type="checkbox"/>	<input type="checkbox"/>
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Transgender: M to F <input type="checkbox"/> Female <input type="checkbox"/> Transgender: F to M		<input type="checkbox"/> Doesn't identify as male, female or transgender	<input type="checkbox"/>	<input type="checkbox"/>
Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish		<input type="checkbox"/> Other, specify:		

HOUSEHOLD INFORMATION

Relationship (to HoH)	SELF	Number in Household:	Use a separate HH Member Supplemental page for each additional HH member
-----------------------	-------------	----------------------	---------------------------------------------------------------------------------

DOMESTIC VIOLENCE

	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Victim/Survivor	(If Yes) how long ago was the last incident? <input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 3-6 months ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> More than a year ago <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused (If Yes) are you currently fleeing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Does Not Know <input type="checkbox"/> Client Refused		

Head of Household Name: _____

LIVING SITUATION

PRIOR LIVING SITUATION: *Where was the client sleeping last night? Or, in other words, what was the client's living situation just prior to entering this project? For non-residential programs this is their current situation.*

Choose from Literally Homeless Situation OR Institutional Setting OR TH/PSH Situation. Once chosen, stay in that column.

1A. Homeless Situation

- Place not meant for human habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
- Emergency Shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter
- Safe Haven

↓ Next Answer 2A: Length of Stay. ↓

1B. Institutional Situation

- 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

↓ Next Answer 2B: Length of Stay. ↓

1C. Temporary or Permanent Housing Situation

- Residential 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 friend's room, apartment or house
- Staying or living in a family member's room, apartment or house
- Rental by client with GPD TIP housing subsidy
- Rental by client, with VASH housing subsidy
- Permanent housing (other than RRH) for formerly homeless persons
- Rental by client, with RRH or equivalent subsidy
- Rental by client, with Housing Choice Voucher (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

↓ Next Answer 2C: Length of Stay. ↓

2A: LENGTH OF STAY: *How long was the client in a Homeless Situation?*

- One Day or Less
- Two Days to One Week
- > One Week but < One Month
- One to Three Months
- > three months, but < 1 year
- One Year or Longer
- Client Does Not Know
- Client Refused

↓ Next Answer 3: Chronic Questions ↓

2B: LENGTH OF STAY: *How long was the client in an Institutional Situation?*

- One Day or Less[Ⓕ]
- Two Days to One Week[Ⓕ]
- > One Week but < One Month[Ⓕ]
- One to Three Months[Ⓕ]
- > three months, but < 1 year
- One Year or Longer
- Client Does Not Know
- Client Refused

3 months or less

[Ⓕ]If the client reported Three Months or less then answer the question below. If the client reports more than 3 months, the client is not chronic, skip the rest of this page.

On the night before the Institutional Situation, did the client stay on the streets, in ES or SH?

- Yes (proceed below to 3: Chronic Questions)
- No (the client is NOT Chronic, skip the rest of this page)

2C: LENGTH OF STAY: *How long was the client in a Housing Situation?*

- One Day or Less[Ⓕ]
- Two Days to One Week[Ⓕ]
- > One Week but < One Month
- One to Three Months
- > three months, but < 1 year
- One Year or Longer
- Client Does Not Know
- Client Refused

1 week or less

[Ⓕ]If the client reported One Week or less then answer the question below. If the client reports 7 days or more, then the client is not chronic, skip the rest of this page.

On the night before the TH/PH Housing Situation, did the client stay on the streets, in ES or SH?

- Yes (proceed below to 3: Chronic Questions)
- No (the client is NOT Chronic, skip the rest of this page)

Head of Household Name: _____

3: CHRONIC QUESTIONS: (depending on your answer in the above questions).

3.1: Approximate Date <u>this current episode</u> of homelessness began? Have the client look back to the date of the last time the client had a place to sleep for more than 7 days that was not on the streets in ES or SH.	M/D/Y
3.2: Regardless of where they stayed last night -- Number of times (episodes) the client has been homeless on the streets, in ES, or SH in the past three years including today. If this is the first time the client has been homeless in the past 3 years then the response is One Time. <ul style="list-style-type: none"> A NEW EPISODE SHOULD BE COUNTED AFTER EACH TIME THE CLIENT HAD HOUSING FOR 7 DAYS OR LONGER (AT A FRIEND'S OR FAMILY MEMBER'S OR OTHER NON-HOMELESS SITUATION) OR WAS IN AN INSTITUTIONAL SETTING FOR 90 DAYS OR MORE. 	<input type="checkbox"/> One Time <input type="checkbox"/> Two Times <input type="checkbox"/> Three Times <input type="checkbox"/> Four or more times <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
3.3: Total number of months on the street, in ES or SH in the past 3 years: the number of cumulative but not necessarily consecutive months spent homeless.	Number of Months

Client Location

Choose the continuum where the client is located (in most cases this will be "IL-514 DuPage")

- | | | |
|---------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> IL-514 DuPage | <input type="checkbox"/> IL-502 Waukegan/North Chicago/Lake | <input type="checkbox"/> IL-512 Bloomington/Central Illinois |
| <input type="checkbox"/> IL-511 SubCook | <input type="checkbox"/> IL-506 Joliet/Kendall/Grundy | <input type="checkbox"/> IL-518 Northwest/LaSalle |
| <input type="checkbox"/> IL-517 Aurora/Elgin/Kane | <input type="checkbox"/> IL-509 De Kalb | |

City and Zip where client stays or spends most of their time

Current City _____ Current Zip _____

DISABILITY

Does the client have a disabling condition expected to be of long duration and impedes ability to live independently?

- Yes No Doesn't Know Refused

Disability Type	(If Yes) Start Date	Currently receiving Services or Treatment?	Will the Condition be long term?	Disability Determination
Alcohol Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	_____ / _____ / _____ If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? Notes:	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	_____ / _____ / _____ If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? Notes:	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Alcohol and Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	_____ / _____ / _____ If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? Notes:	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Chronic Health Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know	_____ / _____ / _____ If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Agency's LOGO

Head of Household Name: _____

<input type="checkbox"/> Client Refused	Notes:				
HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:				
Mental Health Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:				
Developmental Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:				
Physical Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:				

INCOME

Does the household have any current income?

Yes
 No
 Client Does Not Know
 Client Refused

If No, move on to Household Income for AMI Below:

If Yes, indicate in each source if the household receives the income, and if they do, the household member receiving the income, the monthly amount (to the nearest dollar) of each source, and the income start date.

			HH Member	Amount	Start Date	HH Member	Amount	Start Date
Earned Income								
<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes:				\$			\$	
				\$			\$	
Unemployment Insurance								
<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes:				\$			\$	
SSI: Supplemental Security Income								
<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes:				\$			\$	
Social Security Disability Income								
<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes:				\$			\$	
VA Service Connected								
<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes:				\$			\$	
Private Disability Insurance								
<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes:				\$			\$	

Agency's LOGO



Head of Household Name: _____

Worker's Compensation								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Temporary Assistance for Needy Families (TANF)								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
General Assistance								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Retirement Income from Social Security								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
VA Non-Service Connected								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Pension from a former job								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Child Support								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Alimony or Other Spousal Support								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Other Source (specify):								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	

TOTAL MONTHLY HOUSEHOLD INCOME \$ _____
FY2019 AREA MEDIAN INCOME (AMI)

NUMBER OF HOUSEHOLD MEMBERS _____

Household Size	1	2	3	4	5	6	7	8
30% AMI	\$1,563	\$1,783	\$2,008	\$2,229	\$2,408	\$2,588	\$2,767	\$2,946
50% AMI	\$2,600	\$2,971	\$3,342	\$3,713	\$4,013	\$4,308	\$4,604	\$4,904
80% AMI	\$4,163	\$4,754	\$5,350	\$5,942	\$6,421	\$6,896	\$7,371	\$7,846
100% AMI	\$5,200	\$5,942	\$6,683	\$7,425	\$8,025	\$8,617	\$9,208	\$9,808

TOTAL MONTHLY HOUSEHOLD INCOME AS PERCENTAGE OF AMI:

BELOW 30% 30%-49% GREATER THAN 50%

NON-CASH BENEFITS

Does the household currently receive any Non-Cash Benefits?

Yes No Client Does Not Know Client Refused

Please indicate which of the following non-cash benefits have you received over the last 30 days.

(You may use "All" if all household members receive the benefit)

Food stamps or money for food on a benefits card (If yes, amount of benefit)	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, Household Members: _____	
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, Household Members: _____	
TANF child care services	

Agency's LOGO



Head of Household Name: _____

<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
TANF transportation services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Other TANF-Funded Services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Other Source (specify):	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:

HEALTH INSURANCE

Do household members currently have health insurance?

Yes No Client Does Not Know Client Refused

Complete the following (You may use "All" if all household members receive the benefit)

Medicaid	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Medicare	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Illinois All Kids (State Children's Health Insurance Program)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Veteran's Administration Medical Services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Employer Provided Health Insurance	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Health Insurance obtained through COBRA	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Private Pay Health Insurance	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
State Health Insurance for Adults	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Indian Health Services Program	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Other	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
If "Yes" to Other, Specify Source:	

Agency's LOGO



Head of Household Name: _____

CLIENT'S RESIDENCE/LAST PERMANENT ADDRESS

For SSVF Projects, this is where the client lived for 90 days or more before coming to your project

Client's Street Address				Apt #	
City, Township		State		Zip	
Address Data Quality	<input type="checkbox"/> Full Address Reported <input type="checkbox"/> Client Does Not Know		<input type="checkbox"/> Incomplete or estimated address reported <input type="checkbox"/> Client Refused		
Phone Number		Alternate Phone			
Email Address					
Start Date		End Date			
Client's Residence Notes					
Address Type	<input type="checkbox"/> After Program <input type="checkbox"/> Before Program-Last Permanent		<input type="checkbox"/> Before Program <input type="checkbox"/> Program (while in your project)		

EMERGENCY CONTACT (OPTIONAL)

Contact's Name					
Client's Street Address				Apt #	
City, Township		State		ZIP	
Phone #		Second Phone #			
Relationship to Client					
Start Date		End Date			
Is there a release of information to contact this person?	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Agency's LOGO



Head of Household Name: _____

[Intentionally left blank]

Agency's LOGO



Head of Household Name: _____

Universal Intake Form

Household Member

HMIS CLIENT ID#	INTAKE/ENTRY DATE
FILL-IN AFTER SERVICEPOINT ENTRY	MONTH / DAY / YEAR

NAME OF HOUSEHOLD MEMBER (first, middle, last name, suffix (e.g., Jr, Sr, III))				Client does not know	Client refused
First Name	Middle Name			<input type="checkbox"/>	<input type="checkbox"/>
Last Name	Alias/Suffix			<input type="checkbox"/>	<input type="checkbox"/>
SSN		Approx. or Partial SSN Reported <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Veteran Status	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Veteran Status is on the Client Profile Tab and may need to be updated if the client is already in ServicePoint.</i>			<input type="checkbox"/>	<input type="checkbox"/>
Relationship (to HoH)	<input type="checkbox"/> HoH's Child <input type="checkbox"/> HoH's Other Relation <input type="checkbox"/> HoH's Spouse/Partner <input type="checkbox"/> Other: Non-Relation			NA	NA
Date of Birth		Approx. or Partial DOB Reported <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Primary Race	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other			<input type="checkbox"/>	<input type="checkbox"/>
Secondary Race (Leave Blank if None)	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other			NA	NA
Ethnicity	<input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Hispanic/Latino			<input type="checkbox"/>	<input type="checkbox"/>
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Transgender: M to F <input type="checkbox"/> Doesn't identify as male, female or transgender <input type="checkbox"/> Female <input type="checkbox"/> Transgender: F to M			<input type="checkbox"/>	<input type="checkbox"/>
Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other, specify:			<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Victim/Survivor	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/>	<input type="checkbox"/>
	(If Yes) how long ago was the last incident? <input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 3-6 months ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> More than a year ago <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused				
	(If Yes) are you currently fleeing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Does Not Know <input type="checkbox"/> Client Refused				

Head of Household Name: _____

Member Name: _____

DISABILITY

Does the client have a disabling condition?

- Yes No Doesn't Know Refused

Disability Type	(If Yes) Start Date	Currently receiving Services or Treatment?	Will the Condition be long term?	Disability Determination	Documentation of disability and severity on file
Alcohol Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
	Notes:				
Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
	Notes:				
Alcohol and Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
	Notes:				
Chronic Health Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
	Notes:				
HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
	Notes:				
Mental Health Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
	Notes:				
Developmental Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
	Notes:				
Physical Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
	Notes:				