



Transitional Housing, Rapid Rehousing, Permanent Supportive Housing, and all other Projects (Single Individual)
(complete this form for ALL adults)

Client Name: _____
Project Start Date: _____
SS#: _____ DOB ____/____/____

ROI Signed? Yes ___ No ___
Veteran? Yes ___ No ___

Race: ___ American Indian/ Alaska Native
___ Asian
___ Black/ African American
___ Native Hawaiian/ Pacific Islander
___ White

Ethnicity: ___ Hispanic/ Latino
___ Non-Hispanic/ Latino

Gender: ___ Female
___ Male
___ Trans Female (MTF or Male to Female)
___ Trans Male (FTM or Female to Male)
___ Gender Non-conforming (ie: not exclusively male or female)

Relationship to Head of Household:
___ Self (Head of Household)
___ Head of Household's Child
___ Head of Household's Spouse/ Partner
___ Head of Household's Other Relative
___ Other: Non-Relative

Residence Prior to Project Entry (Where did you sleep last night?)

Homeless Situation: (Skip to the Homeless Situation Question next)

- ___ Place not meant for human habitation
___ Emergency shelter, including hotel or motel paid for with emergency shelter voucher
___ Safe Haven
___ Interim Housing

Institutional Situation:

- ___ Foster care home/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/detox center

Did you stay less than 90 days? Yes ___ No ___

If yes, prior to Institutional Stay were you living on the streets or in a shelter? Yes ___ No ___

(If yes, answer the Homeless Situation Questions)

Transitional and Permanent Housing Situation:

- ___ Hotel or motel paid without emergency voucher ___ Owned by client, no on-going housing subsidy
___ Owned by client, with on-going housing subsidy
___ Permanent housing (other than RRH) for formerly homeless persons
___ Rental by client, no ongoing housing subsidy ___ Rental by client, with VASH Subsidy
___ Rental by client, with GPD TIP subsidy ___ Rental by client, with other ongoing housing subsidy
___ Residential project or halfway house with no homeless criteria
___ Staying in family member's room/apartment/house
___ Staying in friend's room/apartment/house
___ Transitional housing for homeless persons (including homeless youth)



Homeless Situation Questions:

Length of Stay in Previous Place:

One day or less
 Two days to one week
 More than one week, less than one month
 One to three months
 More than three months, less than one year
 One year or longer

Approximate Date Homelessness Started: ___/___/_____

of times (episodes) on streets or in ES in 3 years: ___1 ___2 ___3 ___4 or more

Total number of months homeless on the street, in ES in the past 3 years: _____ Months

Homeless/Housing At Risk Primary Reason: (Select/ identify #1 and #2)

- | | | |
|---|---|--|
| <input type="checkbox"/> Conflict in the household | <input type="checkbox"/> Conflict w/ guardian | <input type="checkbox"/> Underemployment/ Low Income |
| <input type="checkbox"/> Criminal activity | <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Eviction |
| <input type="checkbox"/> Health/ Safety | <input type="checkbox"/> Lack of sufficient Housing | <input type="checkbox"/> Loss of Child Care |
| <input type="checkbox"/> Loss of Job | <input type="checkbox"/> Loss of Public Assistance | <input type="checkbox"/> Loss of Transportation |
| <input type="checkbox"/> Medical Condition | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Mortgage Foreclosure |
| <input type="checkbox"/> Mutual Agreement (Respite) | <input type="checkbox"/> No Affordable Housing | <input type="checkbox"/> Release from Institution |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Utility Shut Off | <input type="checkbox"/> Substandard Housing |

Income:

Do you have income? ___Yes ___ No **Total Monthly Income \$**_____

Income Source and amount:

- | | |
|---|--|
| \$_____ Alimony/ Spousal Support | \$_____ Child Support |
| \$_____ Earned Income | \$_____ General Assistance |
| \$_____ Pension or retirement income from another job | |
| \$_____ Private Disability Insurance | \$_____ Retirement Income from Social Security |
| \$_____ Social Security Disability Income (SSDI) | \$_____ Social Security Income (SSI) |
| \$_____ Temporary Assist for Needy Families TANF | \$_____ Unemployment Insurance |
| \$_____ VA Non-Service-Connected Disability Pension | \$_____ VA Service-Connected Disability Compensation |
| \$_____ Worker's Compensation | |

Non-Cash Benefits:

Do you have Non-Cash Benefits? ___Yes ___ No **Monthly Amount \$**_____

Source of Non-Cash Benefits:

- Supplemental Nutrition Assistance Program (SNAP) (HUD) (Previously known as Food Stamps)
 Special supplemental Nutrition Program for (WIC) (HUD)
 TANF Child Care Services (HUD)
 TANF Transportation Services (HUD)
 Other TANF-Funded Services (HUD); If "Other" Specify: _____

Medical Insurance:

Do you have Health Insurance/ Medical Assistance? ___Yes ___ No



Source of Health Insurance/ Medical Assistance:

- ___ Medicaid ___ Medicare
- ___ State Children’s Health Insurance Program ___ Veteran’s Administration (VA) Medical Services
- ___ Employer – Provided Health Insurance ___ Health Insurance obtained through COBRA
- ___ State Health Insurance for Adults
- ___ Indian Health Care ___ Other

Medicaid ID# _____

Medicaid Insurance Company: ___ Total Care ___ Blue Cross Blue Shield ___ Fidelis
___ United Healthcare ___ Molina Healthcare

Disabling Condition:

- Do you have a **DISABILITY** of long duration? ___ Yes ___ No
- If yes, do you have determination of Disability? ___ Yes ___ No
- If yes, are you currently receiving treatment for Disability? ___ Yes ___ No

Disability Type:

- ___ Alcohol Abuse ONLY ___ BOTH Alcohol & Drug Abuse ___ Drug Abuse ONLY
- ___ Chronic Health Condition ___ Developmental ___ HIV/AIDS
- ___ Mental Health ___ Physical Health

Date of Engagement: ___/___/___ (Complete upon client entering Service Plan development or fully completed initial assessment)

Referral Source:

- ___ Self-Referral ___ Outreach Provider ___ Temporary Shelter ___ Residential Project
- ___ Individual: Parent/ Guardian/ Relative/ Friend/ Foster Parent/ Other Individual
- ___ Hotline ___ Child Welfare/ CPS ___ Juvenile Justice ___ Mental Hospital
- ___ Law Enforcement/ Police ___ School ___ Other Organization

If Outreach Project is selected, Number of times approached by outreach prior to entering the project: ___ times

Date of BCP (Basic Center Program) Status Determination: ___/___/___

Youth Eligible for RHY Services: ___ Yes ___ No

If no for “Youth Eligible for RHY Services,” Reason why services are not funded by BCP grant:

- ___ Out of Range ___ Ward of the State – Immediate Reunification
- ___ Ward of Criminal Justice System – Immediate Reunification
- ___ Other: _____

If yes for “Youth Eligible for RHY Services,” runaway youth: ___ Yes ___ No

Sexual Orientation:

___ Heterosexual ___ Gay ___ Lesbian ___ Bisexual ___ Questioning/ Unsure

Last Grade Completed:

- ___ Less than Grade 5 ___ Grades 5-6 ___ Grades 7-8 ___ Grades 9-11
- ___ Grades 12/ HS Diploma ___ School Program Doesn’t have grade levels
- ___ GED ___ Some College ___ Associates Degree ___ Bachelor’s Degree



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___ Graduate Degree ___ Vocational Certification

School Status:

___ Attending School Regularly ___ Attending School Irregularly ___ Graduated Already
___ Obtained GED ___ Dropped out ___ Suspended
___ Expelled

Employment History:

Employed? ___ Yes ___ No If yes, Type of Enrollment: ___ Full time ___ Part time ___ Seasonal/ sporadic
If no, why not employed? ___ Looking for work ___ Unable to work ___ Not looking for work

General Health Status:

___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

Mental Health Status:

___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

Dental Health Status:

___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

Pregnant? ___ Yes ___ No If yes, Projected Birth Date: ___/___/___

Formerly a Ward of the Child Welfare/ Foster Care Agency? ___ Yes ___ No

Number of Years: ___ Less than one year ___ 1 to 2 years ___ 3 to 5 years or more
If less than One year, number of months: _____ months

Formerly a Ward of the Juvenile Justice System? ___ Yes ___ No

Number of Years: ___ Less than one year ___ 1 to 2 years ___ 3 to 5 years or more
If less than One year, number of months: _____ months

Family Critical Issues:

Under Employment – Family member? ___ Yes ___ No
Mental Health Issues – Family member? ___ Yes ___ No
Physical Disability – Family member? ___ Yes ___ No
Alcohol or Substance Abuse – Family member? ___ Yes ___ No
Insufficient Income to support youth – Family member? ___ Yes ___ No
Incarcerated Parent of Youth? ___ Yes ___ No

Are you a Victim/ Survivor of Domestic Violence? ___ Yes ___ No

If yes, when did it last occur: ___ Within the past 3 months ___ 3 to 6 months ___ 6 to 12 months
 ___ More than 12 months ___ Refused

Are you currently fleeing? ___ Yes ___ No