Housing & Homeless Coalition
Of Central New York

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315-428-2216

**Emergency Shelter/ Street Outreach Intake Form (Single Individual)**
(Complete this form for ALL adults)

**Client Name:** _____
Project Start Date: _____ **ROI Signed?** Yes ____ No ____
**SS#:** _ _ _ - _ _ - _ _ _ _ **DOB**___/___/_____ **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 (chose only one):
____ 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

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)

**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

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**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)

____ Conflict in the household
____ Criminal activity
____ Health/ Safety
____Loss of Job
____ Medical Condition
____ Mutual Agreement (Respite)
____ Substance Abuse
____ Conflict w/ guardian
____ Domestic Violence
____ Lack of sufficient Housing
____ Loss of Public Assistance
____Mental Health
____ No Affordable Housing
____ Utility Shut Off
____ Underemployment/ Low Income
____ Eviction
____ Loss of Child Care
____ Loss of Transportation
____ Mortgage Foreclosure
____ Release from Institution
____ Substandard Housing

**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

**Do you have Non-Cash Benefits?** ____Yes ____ No **Monthly Amount** $_____

Source of Non-Case 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: _____

**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

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**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 | |

**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

**<u>Outreach Sub-assessment:</u>**
Date of Contact: ___/___/_____ Staying on Street or Emergency Shelter? ____Yes ____ No
Start Date: ___/___/_____ End Date: ___/___/_____

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

**Housing Move In Date: ___/___/___** (Complete if moving into PERMANENT HOUSING)