



www.hhccny.org
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315-428-2216

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

Primary Language: ____ Arabic ____ Armenian ____ Bangali ____ Catonese ____ Chinese ____ English
____ French ____ French Creole ____ German ____ Greek ____ Gujarati ____ Hatian Creole ____ Hebrew
____ Hindi ____ Hmong ____ Italian ____ Japanese ____ Korean ____ Mandarin ____ Panjabi ____ Persian
____ Polish ____ Portuguese ____ Russian ____ Spanish ____ Tagalog ____ Telugu ____ Urdu
____ Vietnamese ____ Yiddish

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

Zip Code of Last Permanent Address: _____

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)



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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

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

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

Legal Status:

Are you on Parole: ___ Yes ___ No If yes, Parole Officer: _____
Phone Number: _____ - _____ - _____



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If you left the program today, where would you go?

- Place not meant for human habitation
- Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- 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
- Hotel or motel paid without emergency voucher
- Owned by client, no on-going housing subsidy
- Owned by client, with on-going housing subsidy
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- 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, temporary tenure
- Staying in family member's room/apartment/house, permanent tenure
- Staying in friend's room/apartment/house, temporary tenure
- Staying in friend's room/apartment/house, permanent tenure
- Transitional housing for homeless persons (including homeless youth)

Personal Phone Number: _____ - _____ - _____