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Entry Assessment for Permanent Supportive Housing Projects (Single Individuals and Adults)
(complete this form for ALL adults)

Client Name: _____ HMIS Client ID#: _____
(optional)
Project Start Date: _____ **ROI Signed?** Yes ____ No ____
SS#: _ _ _ - _ _ - _ _ _ _ **DOB**___/___/_____ **Veteran?** Yes ____ No_____

Race: (Select as many as client identifies)
____ American Indian/ Alaska Native or Indigenous
____ Asian or Asian American
____ Black, African American, or African
____ Native Hawaiian or Pacific Islander
____ White

Ethnicity: ____ Hispanic/ Latin(a)(o)(x)
____ Non-Hispanic/ Latin(a)(o)(x)

Gender: (Select as many as client identifies)
____ Female
____ Male
____ Transgender (clients who live or identify with a transgender history, experience, or identity)

____ A gender that is not singularly 'Female' or 'Male' (e.g., non-binary, genderfluid, agender, culturally specific gender)
____ Questioning (Unsure, ay be exploring, or may not relate to or identify with a gender identity at this time)

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 Relation Member
____ Other: Non-Relation Member

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

<u>Medical Insurance:</u>
Do you have Health Insurance/ Medical Assistance? ____Yes ____ No
Source of Health Insurance/ Medical Assistance:
_____ Medicaid _____ Medicare
_____ State Children's Health Insurance Program
_____ Employer – Provided Health Insurance
_____ Veteran's Administration (VA) Medical Services
_____ Health Insurance obtained through COBRA

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_____ 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

For each disability, check "LCI" if it is expected to be of long, continued and indefinite duration, substantially impairs the individual's ability to live independently, and is of such a nature that such ability could be improved by more suitable housing conditions.

Disability Type:

__Yes __LCI Alcohol Use Disorder __Yes__LCI BOTH Alcohol & Drug Use Disorder __Yes__LCI Drug Use Disorder
__Yes__LCI Chronic Health Condition __Yes__LCI Developmental _____ HIV/AIDS
__Yes__LCI Mental Health Disorder __Yes__LCI Physical Health

Client Location: ____ NY-505 (Onondaga/ Cayuga/ Oswego counties)
____ NY-510 (Ithaca/ Tompkins County)

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)

Transitional and Permanent Housing Situation:

____ Hotel or motel paid without emergency voucher ____ Owned by client, no on-going housing subsidy

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____ 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

Reasons for Homelessness (Please answer for each adult in the household)
In the past year (12 months), did you experience any of the following:

1. Doubled up with friends of family for more than 1 week? ____Yes ____ No
2. Lived in a place where an eviction suit was brough against you or the lease holder? ____Yes ____ No
3. Lived in a place that was declared unfit for human habitation by city/town code enforcement? ____Yes ____ No
4. Received county public assistance and lost it for any reason? ____Yes ____ No
5. Went to the emergency room or hospital for mental health reasons? ____Yes ____ No
6. Had a large medical expense? ____Yes ____ No
7. Released from state prison or other long-term criminal justice institution? ____Yes ____ No
8. Had some other involvement with the criminal justice system (including probation/parole) ____Yes ____ No
9. Had utilities shut of? ____Yes ____ No

Income:
Do you have income? ____Yes ____ No **Total Monthly Income** $_____
Income Source and amount: (please write in the monthly amount in the lines provided)

$_____ 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)

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$_____ 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: _____

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)

Well-being Assessment: Information Date: ____/____/_____

Client Perceives their life has value and worth.
____ Strongly disagree ____ Somewhat disagree ____ Neither agree nor disagree ____ Somewhat agree ____ Strongly agree

Client Perceives they have support from others who will listen to problems.
____ Strongly disagree ____ Somewhat disagree ____ Neither agree nor disagree ____ Somewhat agree ____ Strongly agree

Client perceives they have a tendency to bounce back after hard times.
____ Strongly disagree ____ Somewhat disagree ____ Neither agree nor disagree ____ Somewhat agree ____ Strongly agree

Client's frequency of feeling nervous, tense, worried, frustrated, or afraid.
____ One-time event ____ Once a Week ____ Twice a Week ____ Three Times a Week ____ Four or more times a Week ____ Once a Month ____Twice a Month ____ Three Times a Month ____ Four Times a Month

Legal Status:

Are you on Parole: ____Yes ____ No If yes, Parole Officer: _____
Phone Number: _____ - _____ - _____

Personal Phone Number: _____ - _____ - _____