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

Client Name: ________________________________
HMIS Client ID#: ____________________________

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  Haitian Creole  Hebrew
Hindi  Hmong  Italian  Japanese  Korean  Mandarin  Panjabi  Persian
Polish  Portuguese  Russian  Spanish  Tagalog  Telugu  Urdu
Vietnamese  Yiddish

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
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
__Yes__LCI 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
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  $_____ Retirement Income from Social Security
$_____ Private Disability Insurance  $_____ Social Security Disability Income (SSDI)
$_____ Social Security Income (SSI)
Temporary Assistance 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: ______ - ______ - ________