Housing & Homeless Coalition
Of Central New York

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315-428-2216

Permanent Supportive Housing Entry for Children ONLY (Children in Households)
(Please complete this form for ALL Children under 18 years of age)

Client Name: _____ HMIS Client ID#: _____ (optional)
Project Start Date: _____
SS#: _ _ _ - _ _ - _ _ _ _ **DOB**___/___/_____ **Zip Code of Last Permanent Address:** _____

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

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

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

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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

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 {RRH, PSH or OPH})

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