



1. Intake Summary

Intake Date MM/DD/YYYY

Intake Staff Name

Program Name

Client ID (Computer Generated)

2. Basic Client Profile (Universal Data Elements)

First Name MI Last Name Suffix

Form with fields for SS#, Date of Birth, SS Quality, Gender, Ethnicity, Race, Veteran Status, Disabling Condition, Residence Prior to Program Entry, Length of Stay in Previous Residence, Housing Status, Zip Code of Last Perm. Residence, and Zip Code Type.



**3. Detailed Client Information** (Program-Level Data Elements)

<b>Chronic Homelessness::</b>			
<b>Homeless Status</b>	<input type="checkbox"/> Continuously Homeless for a Year or More <input type="checkbox"/> 4 Episodes of Homelessness in the Past 3 Years		
<b>Barriers::</b>			
<b>Substance Abuse Problem</b>  <i>If Yes, expected to be of long-continued/indefinite duration; substantially impairs ability to live independently</i>	<input type="checkbox"/> No <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<b>Mental Health Problem</b>  <i>If Yes, expected to be of long-continued/indefinite duration; substantially impairs ability to live independently</i>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	
<b>Physical Disability</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Refused <input type="checkbox"/> Don't Know	<b>Developmental Disability</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>HIV/AIDS</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Refused <input type="checkbox"/> Don't Know	<b>Chronic Health Condition</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes to any above, currently receiving services/treatment</i>	<input type="checkbox"/> Physical Disability <input type="checkbox"/> Development Disability <input type="checkbox"/> Chronic Health Condition	<input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
<b>Domestic Violence</b> (Adults and Unaccompanied Youth only)::			
<b>DV Victim/Survivor</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<b>If Yes, When Experience Occurred</b> <input type="checkbox"/> Within past three months <input type="checkbox"/> Three to six months ago <input type="checkbox"/> From six to twelve months ago <input type="checkbox"/> More than a year ago <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
<b>Income::</b>			
<b>Income Received from Any Source in Last 30 Days</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused		<b>Non-Cash Benefits Received in Last 30 Days</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
<b>Monthly Income</b>	<input type="checkbox"/> A Veterans' Disability Payment <input type="checkbox"/> Alimony or Other Spousal Support <input type="checkbox"/> Child Support <input type="checkbox"/> Earned Income <input type="checkbox"/> General Assistance <input type="checkbox"/> No Financial Resources <input type="checkbox"/> Other <input type="checkbox"/> Pension from a Former Job <input type="checkbox"/> Private Disability Insurance <input type="checkbox"/> Retirement Income from Social Security <input type="checkbox"/> SSDI <input type="checkbox"/> SSI <input type="checkbox"/> TANF <input type="checkbox"/> Unemployment Income <input type="checkbox"/> Veteran's Pension <input type="checkbox"/> Worker's Compensation		<b>Non-Cash Benefits</b> <input type="checkbox"/> Supplemental Nutritional Assistance Program (Food Stamps) <input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> SCHIP <input type="checkbox"/> Special Supplementation Nutritional Program for WIC <input type="checkbox"/> VA Medical Services <input type="checkbox"/> TANF Child Care Services <input type="checkbox"/> TANF Transportation Services <input type="checkbox"/> Other TANF-Funded Services <input type="checkbox"/> Section 8, Public Housing, or other ongoing rental assistance <input type="checkbox"/> Other Source <input type="checkbox"/> Temporary Rental Assistance



<b>Employment (Adults and Unaccompanied Youth only)::</b>			
<b>Currently Employed</b>	<input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<b>If Yes, Number of Hours Worked in Past Week</b>	_____ hours
<b>If Not Working, is Client Looking for Work</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<b>Employment Tenure</b>	<input type="checkbox"/> Permanent <input type="checkbox"/> Don't Know <input type="checkbox"/> Temporary <input type="checkbox"/> Refused <input type="checkbox"/> Seasonal
<b>Education (Adults and Unaccompanied Youth only)::</b>			
<b>Currently in School</b>	<input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<b>Received Vocational Training or Apprenticeship Certificates</b>	<input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
<b>Highest Level of School Completed</b>	<input type="checkbox"/> No Schooling Completed <input type="checkbox"/> Nursery School to 4 <sup>th</sup> Grade <input type="checkbox"/> 5 <sup>th</sup> or 6 <sup>th</sup> Grade <input type="checkbox"/> 7 <sup>th</sup> or 8 <sup>th</sup> Grade <input type="checkbox"/> 9 <sup>th</sup> Grade <input type="checkbox"/> 10 <sup>th</sup> Grade <input type="checkbox"/> 11 <sup>th</sup> Grade <input type="checkbox"/> 12 <sup>th</sup> Grade, No Diploma <input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> Post-Secondary School <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<b>If client has received high school diploma, GED or enrolled in post secondary education, what degree(s) has the client earned</b>	<input type="checkbox"/> None <input type="checkbox"/> Associates Degree <input type="checkbox"/> Bachelors <input type="checkbox"/> Masters <input type="checkbox"/> Doctorate <input type="checkbox"/> Other Graduate/Professional Degree <input type="checkbox"/> Certificate/Advanced Training or Skilled Artisan <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
<b>Health (Adults and Unaccompanied Youth only)::</b>		<b>Pregnancy Status (All females of child bearing age)::</b>	
<b>General Health Status</b>	<input type="checkbox"/> Excellent <input type="checkbox"/> Poor <input type="checkbox"/> Very Good <input type="checkbox"/> Don't Know <input type="checkbox"/> Good <input type="checkbox"/> Refused <input type="checkbox"/> Fair	<b>Pregnant?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
		<i>If Yes, Due Date</i>	____ / ____ / ____ MM                      DD                      YYYY
<b>Children's Education (for Children ages 5-17)::</b>			
<b>Currently Enrolled in School</b>	<input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<b>If Yes, Name of Child's School</b>	_____
<b>If yes, is/was child connected to the McKinney-Vento Homeless Assistance Act School Liaison</b>	<input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<b>Type of School</b>	<input type="checkbox"/> Public School <input type="checkbox"/> Parochial or Other Private School
<b>If Not Enrolled, Problems Enrolling Child</b>	<input type="checkbox"/> None <input type="checkbox"/> Residency Requirements <input type="checkbox"/> Availability of School Records <input type="checkbox"/> Birth Certificates <input type="checkbox"/> Legal Guardianship Requirements <input type="checkbox"/> Transportation <input type="checkbox"/> Lack of Available Preschool <input type="checkbox"/> Immunization Requirements <input type="checkbox"/> Physical Examination Records <input type="checkbox"/> Other	<b>If Not Enrolled, Date of Last Enrollment</b>	____ / ____ / ____ MM                      DD                      YYYY