





**Length of Stay in Prior Living Situation**

<input type="checkbox"/>	One night or less	<input type="checkbox"/>	Two to six nights	<input type="checkbox"/>	One week or more, but less than one month
<input type="checkbox"/>	One month or more, but less than 90 days	<input type="checkbox"/>	90 days or more, but less than one year	<input type="checkbox"/>	One year or longer
<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
<input type="checkbox"/>	Unknown				

**Approximate date homelessness started:**

		/			/				
Month			Day			Year			

**Regardless of where they stayed last night - Number of times the client has been on the streets, in ES, or SH in the past three years including today:**

<input type="checkbox"/>	One Time	<input type="checkbox"/>	Two times	<input type="checkbox"/>	Three times
<input type="checkbox"/>	Four or more times	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/>	Long-term care facility or nursing home	<input type="checkbox"/>	Substance abuse treatment facility or detox center

**Total number of months homeless on the street, in ES, or SH in the past three years:**

<input type="checkbox"/>	One month (this is the first time)	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4
<input type="checkbox"/>	5	<input type="checkbox"/>	6	<input type="checkbox"/>	7	<input type="checkbox"/>	8
<input type="checkbox"/>	9	<input type="checkbox"/>	10	<input type="checkbox"/>	11	<input type="checkbox"/>	12
<input type="checkbox"/>	More than 12	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected

**INCOME & SOURCES \*PROOF NEEDED\***

What is the Household total monthly income?

\$ \_\_\_\_\_

Have you received income from any source?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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If yes for "Income from any source:

Indicate all sources and dollar amounts for the source that apply:

No	Yes	Source of Income	Amount	No	Yes	Source of Income	Amount
<input type="checkbox"/>	<input type="checkbox"/>	Earned income (i.e. employment income)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Worker's Compensation	\$
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Security Income (SSI)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Temporary Assistance for Needy Families (TANF)	\$
<input type="checkbox"/>	<input type="checkbox"/>	Social Security Disability Income (SSDI)	\$	<input type="checkbox"/>	<input type="checkbox"/>	General Assistance (GA)	\$

<input type="checkbox"/>	<input type="checkbox"/>	VA Service Connected Disability Compensation	\$	<input type="checkbox"/>	<input type="checkbox"/>	VA Non Service Connected Disability Pension	\$
<input type="checkbox"/>	<input type="checkbox"/>	Retirement Income from Social Security	\$	<input type="checkbox"/>	<input type="checkbox"/>	Responses Pension or retirement income from a former job	\$
<input type="checkbox"/>	<input type="checkbox"/>	Private disability insurance	\$	<input type="checkbox"/>	<input type="checkbox"/>	Child support	\$
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Insurance	\$	<input type="checkbox"/>	<input type="checkbox"/>	Alimony and other spousal support	\$
<input type="checkbox"/>	<input type="checkbox"/>	Other Source (specify	\$				

**NON-CASH BENEFITS \*PROOF NEEDED\***

Have you received non-cash benefits from any source?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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If yes for non-cash benefits from any source and dollar amounts for the source that apply:

No	Yes	Source of Benefit	Amount	No	Yes	Source of Benefit	Amount
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC	\$
<input type="checkbox"/>	<input type="checkbox"/>	SANF Child Care services (or use local name)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Temporary Assistance for Needy Families (TANF)	\$
<input type="checkbox"/>	<input type="checkbox"/>	TANF transportation services (or use local name)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Other TANF unded Services (or use local name)	\$
<input type="checkbox"/>	<input type="checkbox"/>	Section 8, public housing, or other ongoing rental assistance	\$	<input type="checkbox"/>	<input type="checkbox"/>	Temporary rental assistance	\$
<input type="checkbox"/>	<input type="checkbox"/>	Other Source	\$	If yes to "Other" Source, please specify			

**DISABILITY INFORMATION \*PROOF NEEDED\***

Does client have a disability?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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**ALCOHOL ABUSE**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:		/		/		
					Month		Day		Year	

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Is there Documentation of the disability and severity on file?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Currently receiving services/treatment for this disability?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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**CHRONIC HEALTH CONDITION**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:		/		/		
					Month		Day		Year	

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Is there Documentation of the disability and severity on file?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Currently receiving services/treatment for this disability?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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**DEVELOPMENTAL DISABILITY**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:				/		/			
							Month		Day		Year		

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Is there Documentation of the disability and severity on file?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Currently receiving services/treatment for this disability?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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**HIV/AIDS**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:				/		/			
							Month		Day		Year		

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Is there Documentation of the disability and severity on file?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Currently receiving services/treatment for this disability?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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**MENTAL HEALTH CONDITION**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:				/		/			
							Month		Day		Year		

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Is there Documentation of the disability and severity on file?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Currently receiving services/treatment for this disability?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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**PHYSICAL CONDITION**

