1.3 A NC ESG Street Outreach and Emergency Shelter Intake

Project Start Date: _____

HOUSEHOLD INFORMATION

Required Data Entry Fields For All Clients

Answer this section for all persons in household (use additional sheets for larger families)

Full Name	Relationship to Head of Household	SSN	US Military Veteran	Date of Birth mm/dd/yyyy	Gender	Race *(Select all that apply)*
_____ **Name Data Quality** ☐ Full name ☐ Partial, street or code name ☐ Client doesn't know ☐ Client refused	☐Self (Head of household)	_____ **SSN Data Quality** ☐Full SSN Reported ☐Approximate or partial SSN reported ☐Client doesn't know ☐Client refused	*(Answer for adults 18+ only)* ☐Yes ☐No ☐Client doesn't know ☐ Client refused	/ / **DOB Data Quality** ☐ Full DOB reported ☐Approximate or partial DOB ☐ Client doesn't know ☐ Client refused	☐ Female ☐ Male ☐ Trans Female (MTF or Male to Female) ☐ Trans Male (FTM or Female to Male) ☐ Gender Non-conforming (i.e. not exclusively male to female) ☐ Client doesn't know ☐ Client refused	☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or other Pacific Islander ☐ White ☐Client doesn't know ☐Client refused
_____ **Name Data Quality** ☐ Full name ☐ Partial, street or code name ☐ Client doesn't know ☐ Client refused	☐Head of Household's child ☐Head of household's spouse or partner ☐Head of household's other relation member (other relation to head of household) ☐Other: non-relation member	_____ **SSN Data Quality** ☐Full SSN Reported ☐Approximate or partial SSN reported ☐Client doesn't know ☐Client refused	*(Answer for adults 18+ only)* ☐Yes ☐No ☐Client doesn't know ☐ Client refused	/ / **DOB Data Quality** ☐ Full DOB reported ☐Approximate or partial DOB ☐ Client doesn't know ☐ Client refused	☐ Female ☐ Male ☐ Trans Female (MTF or Male to Female) ☐ Trans Male (FTM or Female to Male) ☐ Gender Non-conforming (i.e. not exclusively male to female) ☐ Client doesn't know ☐ Client refused	☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or other Pacific Islander ☐ White ☐Client doesn't know ☐Client refused
_____ **Name Data Quality** ☐ Full name ☐ Partial, street or code name ☐ Client doesn't know ☐ Client refused	☐Head of Household's child ☐Head of household's spouse or partner ☐Head of household's other relation member (other relation to head of household) ☐Other: non-relation member	_____ **SSN Data Quality** ☐Full SSN Reported ☐Approximate or partial SSN reported ☐Client doesn't know ☐Client refused	*(Answer for adults 18+ only)* ☐Yes ☐No ☐Client doesn't know ☐ Client refused	/ / **DOB Data Quality** ☐ Full DOB reported ☐Approximate or partial DOB ☐ Client doesn't know ☐ Client refused	☐ Female ☐ Male ☐ Trans Female (MTF or Male to Female) ☐ Trans Male (FTM or Female to Male) ☐ Gender Non-conforming (i.e. not exclusively male to female) ☐ Client doesn't know ☐ Client refused	☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or other Pacific Islander ☐ White ☐Client doesn't know ☐Client refused

HOUSEHOLD INFORMATION continued… Answer this section for all persons in household (use additional sheets for larger families)						
Name *(Answer for All Persons in HH)*	**Ethnicity**	**Does the client have a disabling condition?**	***Disability Type*** ***(Select all that apply)***	**If client has a disabling condition, please answer the following sub-assessment questions.**		
				Disability Determination	*If Yes, to be long-continued and indefinite duration and substantially impairs ability to live independently?*	*Long Term (Yes/ No)*
	☐ Non- Hispanic/ Non-Latino ☐Hispanic/ Latino ☐Client doesn't know ☐Client refused	☐ Yes ☐ No ☐ Client doesn't Know ☐ Client refused	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No
	☐ Non- Hispanic/ Non-Latino ☐Hispanic/ Latino ☐Client doesn't know ☐Client refused	☐ Yes ☐ No ☐ Client doesn't Know ☐ Client refused	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No
	☐ Non- Hispanic/ Non-Latino ☐Hispanic/ Latino ☐Client doesn't know ☐Client refused	☐ Yes ☐ No ☐ Client doesn't Know ☐ Client refused	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No

Disability Notes:

HOUSEHOLD INFORMATION continued… Answer this section for all persons in the household (use additional sheets for larger families)		
Name *(Answer for All Persons in HH)*	**Currently Covered by Health Insurance?**	***(If Client has Health Insurance)*** **Select All Type(s) That Apply**
	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ MEDICAID ☐ MEDICARE ☐ State Children's Health Insurance Program ☐ Veteran Administration (VA) Medical Services ☐ Employer Provided Health Insurance ☐ Health Insurance Obtained through COBRA ☐ Private Pay Health Insurance ☐ State Health Insurance for Adults ☐ Indian Health Services Program ☐ Other (Please Specify:______________________________________)
	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ MEDICAID ☐ MEDICARE ☐ State Children's Health Insurance Program ☐ Veteran Administration (VA) Medical Services ☐ Employer Provided Health Insurance ☐ Health Insurance Obtained through COBRA ☐ Private Pay Health Insurance ☐ State Health Insurance for Adults ☐ Indian Health Services Program ☐ Other (Please Specify:______________________________________)
	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ MEDICAID ☐ MEDICARE ☐ State Children's Health Insurance Program ☐ Veteran Administration (VA) Medical Services ☐ Employer Provided Health Insurance ☐ Health Insurance Obtained through COBRA ☐ Private Pay Health Insurance ☐ State Health Insurance for Adults ☐ Indian Health Services Program ☐ Other (Please Specify:______________________________________)

Homeless History Interview

****Answer the following questions for Head of Household and Adults (Print additional pages where needed) ****

This interview (in conjunction with the client's disability status) is used to determine Homeless Chronicity. Intake workers should not instruct the client on the length of time/# of episodes necessary to qualify as chronically homeless. Questions should be asked in the exact order they are presented below.

Describe the client's living situation (immediately) prior to project entry?

Literally Homeless Situation	Institutional Situation	Transitional/Permanent Housing Situation	Don't Know/Refused
☐ Place not meant for habitation (e.g. a vehicle, abandoned building, bus/train/subway station, airport, anywhere outside).	☐ Foster care home or foster group home	☐ Hotel or motel paid for without emergency shelter voucher	☐ Client doesn't know
☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher.	☐ Hospital or other residential non-psychiatric medical facility	☐ Owned by client, no ongoing housing subsidy ☐ Owned by client, with ongoing housing subsidy ☐ Permanent housing (other than RRH) for formerly homeless persons ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with VASH housing subsidy ☐ Rental by client, with GPD TIP subsidy ☐ Rental by client, with other housing subsidy, (including RRH)	☐ Client refused
☐ Safe Haven	☐ Jail, prison or juvenile detention facility		
☐ Interim Housing (e.g. client applied for permanent housing and a unit/voucher has been reserved but client is not able to move in immediately).	☐ Long-term care facility or nursing home		
	☐ Psychiatric hospital or other psychiatric facility	☐ Residential project of halfway house with no homeless criteria ☐ Staying or living in a family member's room, apartment or house ☐ Staying or living in a friend's room, apartment or house ☐ Transitional housing for homeless persons (including homeless youth)	
	☐ Substance abuse treatment facility or detox center		

ANSWER ALL QUESTIONS BELOW:

Length of Stay in Prior Living Situation?

- ☐ One night or less
- ☐ Two to six nights
- ☐ One week or more but less than one month
- ☐ One month or more but less than 90 days
- ☐ 90 days or more but less than one year
- ☐ One year or longer
- ☐ Client doesn't know
- ☐ Client refused

*Have the client look back to the date of the last time s(he) "had a place to sleep **other than** the streets, ES, or SH".*
If the client knows the month and year but not the day, the worker may substitute the day of the month with the same day of the month as project entry.

What Counts as a Break in Homelessness?

As the client looks back, there may be breaks in their stay on the streets, ES, or SH. A break in homelessness is considered to be:

- ***7 or more consecutive nights in a Housing Situation** (see Section III above).*
- ***90 or more consecutive days in an Institutional Situation** (see Section II above)*

Follow-up questions:

1. *"Did you stay anywhere other than on the streets, in emergency shelter, or safe haven for less than 7 nights" (if not an institution). or*
2. *"Were you in jail/hospital/other Institution less 90 days" (if break is an institution).*

If 1 or 2 is yes, include all those days in the client's total number of days homeless and continue back to the next break in homelessness.

Approximate date homelessness started:_____(M/D/YYYY)

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**

- ☐ One Time
- ☐ Two Times
- ☐ Three Times
- ☐ Four or more Times
- ☐ Client doesn't know
- ☐ Client refused

- ☐ Client doesn't know
- ☐ Client refused

***Total number of months homeless* (on the street, in emergency shelter or safe haven) in the past 3 years?**
(e.g. # of cumulative, but not necessarily consecutive months spent homeless)

- ☐ One month (this time is the first month)
- ☐ 2 – 12 months ➔ Must specify # months_____
- ☐ More than 12 months

Client doesn't know
Client refused

Housing Status

- ☐ Category 1 - Homeless
- ☐ Category 2 – At imminent risk of losing housing
- ☐ Category 3 – Homeless only under other federal statues
- ☐ Category 4 – Fleeing domestic violence
- ☐ At-risk of homelessness
- ☐ Stably Housed
- ☐ Client doesn't know
- ☐ Client refused

Zip Code of Last Permanent Address: _____

Client Location *(CoC Code):*_____**(Answer for Head of Household Only)**

NC County of Service _____

County of Residence: _____

City of Residence: _____

****Answer the following questions for HEAD OF HOUSEHOLD and ADULTS only! (Print additional pages where needed) ****

INCOME & NON-CASH BENEFITS

Currently receiving income from any source?

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client refused

X	Source of Income (Monthly)	Family Member	Amount from Source
	Alimony or Other Spousal Support		$ .00
	Child Support		$ .00
	Earned Income *(Employment)*		$ .00
	General Assistance		$ .00
	Pension or Retirement Income from a Former Job		$ .00
	Private Disability Insurance		$ .00
	Retirement Income from Social Security		$ .00
	SSDI *(Social Security Disability Insurance)*		$ .00
	SSI *(Supplemental Security Income)*		$ .00
	TANF *(Temporary Assistance for Needy Families or FIP grant)*		$ .00
	Unemployment Insurance		$ .00
	VA Service-Connected Disability Compensation		$ .00
	VA Non-Service-Connected Disability Pension		$ .00
	Workers Compensation		$ .00
	Other *(Including Gifts from Friends and Family)* **Specify**:_____		$ .00
	No Financial Resources		**N/A**

Total Monthly Income $_____(Per Household Member)

Currently receiving any non-cash benefits?

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client refused

X	Source of Non-Cash Benefit (Monthly)	Family Member	Amount (If applicable)
	Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps)		$ .00
	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)		$ .00
	TANF Child Care Services		$ .00
	TANF Transportation Services		$ .00
	Other TANF Funded Services		$ .00
	Other Source – **Specify**: _____		$ .00

DOMESTIC VIOLENCE

*Domestic Violence Victim/Survivor should be indicated as **"Yes"** if the person has experienced any domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has taken place **within the individual's or family's primary nighttime residence.***

Domestic Violence Victim/Survivor?

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client refused

***(If yes)* When Experience Occurred**

- ☐ Within the past three months
- ☐ Three to six months ago (excluding six months exactly)
- ☐ Six months to one year ago (excluding one year exactly)
- ☐ One year ago or more
- ☐ Client doesn't know
- ☐ Client refused

*Currently fleeing should be indicated as **"Yes"** if the Person is fleeing, or is attempting to flee, the domestic violence situation **or** is afraid to return to their primary nighttime residence.*

***(If yes)* Are you currently fleeing?**

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client refused

Overview of domestic violence

_____

Has Client Lived in an Adult Care Home in 2012? □ No □ Yes □ Client doesn't know □ Client refused

(If Yes) **Adult Care Home Client Lived In Most Recently:**

_____

CONTACT INFORMATION

To obtain the client's emergency contact information, intake staff should ask the client, "*If you wish to be contacted regarding benefits that you may be eligible for or in the case of an emergency, we will need your best Contact Information. Some services are very time limited so please be as accurate as possible and include how we might reach you even as your circumstances are changing."*

Client's Cell Phone Number _____

Emergency Contact's Name _____

Contact Type (Relationship to Client) _____

Phone Number _____

Second Phone Number _____

Email Address _____

Contact's Address: Street _____ **City** _____ **State** _____

Contact's Zip Code _____

Emergency Contact's Name _____

Contact Type (Relationship to Client) _____

Phone Number _____

Second Phone Number _____

Email Address _____

Contact's Address: Street _____ **City** _____ **State** _____

Contact's Zip Code _____

CONTACTS & ENGAGEMENT

(REQUIRED FOR ALL STREET OUTREACH AND NBN SHELTERS)

Street Outreach Projects and **Emergency Shelters using the Night-by-Night Method of Tracking** MUST record the date and if the client is staying on the streets, ES or SH of **EACH CONTACT** made with clients including the **'Date of Engagement**'.
Please see the *HMIS Data Collection – Street Outreach Supplemental Form* and
2017 HUD Data Standards for more information