

**FL-507 Central Florida HMIS
Emergency Shelter Data Collection Guide – ENTRY ASSESSMENT**

Agency/Program: _____ Assessment Date: _____

Section 1: Complete for All Household Members (Adults and Minors)

CLIENT INFORMATION Client Location (CoC code): FL-507

Client Name: First _____ Middle _____ Last _____

Name Data Quality

<input type="checkbox"/> Full Name Reported	<input type="checkbox"/> Partial, Street, or Code Name Reported	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
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Social Security Number _____ - _____ - _____

Social Security Number Data Quality

<input type="checkbox"/> Full SSN Reported	<input type="checkbox"/> Approximate or Partial SSN Reported	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
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Veteran Status

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
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Relationship to Head of Household

<input type="checkbox"/> Self	<input type="checkbox"/> Head of household's spouse or partner	<input type="checkbox"/> Other: non-relation member
<input type="checkbox"/> Head of household's child	<input type="checkbox"/> Head of household's other relation member	

Date of Birth _____ / _____ / _____

Date of Birth Data Quality

<input type="checkbox"/> Full DOB Reported	<input type="checkbox"/> Approximate or Partial DOB Reported	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
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Gender (Select as many as apply)

<input type="checkbox"/> Female	<input type="checkbox"/> A gender that is not singularly "Female" or "Male"	<input type="checkbox"/> Questioning	<input type="checkbox"/> Client Refused
<input type="checkbox"/> Male	<input type="checkbox"/> Transgender	<input type="checkbox"/> Client Doesn't Know	

Race

<input type="checkbox"/> American Indian, Alaska Native, or Indigenous	<input type="checkbox"/> White
<input type="checkbox"/> Asian or Asian American	<input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> Black, African American, or African	<input type="checkbox"/> Client Refused
<input type="checkbox"/> Native Hawaiian or Pacific Islander	

Ethnicity

<input type="checkbox"/> Hispanic/Latin(a)(o)(x)
<input type="checkbox"/> Non-Hispanic/Latin(a)(o)(x)
<input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> Client Refused

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DISABILITY INFORMATION

Does the client have a Disabling Condition?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
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If yes, check all that apply and indicate whether it is long-continued and indefinite duration and substantially impairs ability to live independently.

Disability Type	Long-continued/indefinite duration?
<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Chronic health condition	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Developmental	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Mental Health Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Physical	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Substance Use Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No

HEALTH INSURANCE INFORMATION

Covered by Health Insurance?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
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If yes, check all that apply:

<input type="checkbox"/> Medicaid	<input type="checkbox"/> COBRA
<input type="checkbox"/> Medicare	<input type="checkbox"/> Private Pay Health Insurance
<input type="checkbox"/> State Children's Health Insurance	<input type="checkbox"/> State Health Insurance for Adults
<input type="checkbox"/> VA Medical Services	<input type="checkbox"/> Indian Health Services Program
<input type="checkbox"/> Employer-Provided Health Insurance	<input type="checkbox"/> Other: _____

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Section 2: Complete for Head of Household and All Adults

HOMELESS HISTORY QUESTIONS

Living Situation (Check where the client stayed last night):

HOMELESS SITUATION

<input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, or anywhere outside)
<input type="checkbox"/> Emergency shelter, including hotel/motel paid for with an emergency shelter voucher
<input type="checkbox"/> Safe Haven (this is a type of emergency shelter bed - not Safe Haven Family Shelter)

INSTITUTIONAL SITUATION

<input type="checkbox"/> Jail, prison, or juvenile detention facility
<input type="checkbox"/> Long-term care facility or nursing home
<input type="checkbox"/> Substance abuse treatment or detox center
<input type="checkbox"/> Foster care home or foster care group home
<input type="checkbox"/> Psychiatric Hospital or other psychiatric facility
<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility

TRANSITIONAL OR PERMANENT HOUSING SITUATION

<input type="checkbox"/> Rental by client with VASH subsidy
<input type="checkbox"/> Rental by client with GPD TIP subsidy
<input type="checkbox"/> Owned by client, no ongoing housing subsidy
<input type="checkbox"/> Rental by client, no ongoing housing subsidy
<input type="checkbox"/> Rental by client with other ongoing housing subsidy
<input type="checkbox"/> Owned by client with ongoing housing subsidy
<input type="checkbox"/> Permanent housing for formerly homeless person
<input type="checkbox"/> Staying or living in a friend’s room, apartment, or house
<input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher
<input type="checkbox"/> Residential project or halfway house with no homeless criteria

How long did the client stay there (the place they stayed last night)?

<input type="checkbox"/> One night or less	<input type="checkbox"/> One week or more, but less than one month	<input type="checkbox"/> 90 days or more, but less than one year
<input type="checkbox"/> Two to six nights	<input type="checkbox"/> One month or more, but less than 90 days	<input type="checkbox"/> One year or longer

Approximate date homeless (most current episode without gaps):

____ / ____ / ____

Regardless of where they stayed last night, total # of times (episodes) the client has been on the streets or in an emergency shelter in the past 3 years including today:

<input type="checkbox"/> One time	<input type="checkbox"/> Three times	<input type="checkbox"/> Client doesn’t know
<input type="checkbox"/> Two times	<input type="checkbox"/> Four or more times	<input type="checkbox"/> Client refused

Total # of months the client has been on the street or in an emergency shelter in the past 3 years (round up):

<input type="checkbox"/> 1 (this is the 1st month)	<input type="checkbox"/> 4 months total	<input type="checkbox"/> 7 months total	<input type="checkbox"/> 10 months total	<input type="checkbox"/> More than 12 months
<input type="checkbox"/> 2 months total	<input type="checkbox"/> 5 months total	<input type="checkbox"/> 8 months total	<input type="checkbox"/> 11 months total	<input type="checkbox"/> Client doesn’t know
<input type="checkbox"/> 3 months total	<input type="checkbox"/> 6 months total	<input type="checkbox"/> 9 months total	<input type="checkbox"/> 12 months total	<input type="checkbox"/> Client refused

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COC LOCAL FIELDS

Answer regardless of living situation:

What county were you in when this episode of homelessness began?

<input type="checkbox"/> Orange County	<input type="checkbox"/> Osceola County	<input type="checkbox"/> Seminole County	<input type="checkbox"/> Other	<input type="checkbox"/> N/A
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If other county, please specify **COUNTY** and **STATE**:

Clients' Last Permanent Address:

Street Address: _____

City: _____ State: _____ Zip Code: _____

Address Data Quality:

<input type="checkbox"/> Full Address Reported	<input type="checkbox"/> Incomplete or Estimated Address	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
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Last Permanent Address's Start Date: _____

DOMESTIC VIOLENCE INFORMATION

Is Client a Survivor of Domestic Violence?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
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If yes, when did experience occur?

<input type="checkbox"/> Within the past 3 months	<input type="checkbox"/> 6 to 12 months ago	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> 3 to 6 months ago	<input type="checkbox"/> More than a year ago	<input type="checkbox"/> Client refused

If yes, is the client currently fleeing domestic violence?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
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INCOME INFORMATION

Record each adult's income on their own intake form. If a minor child has income, include it on the HoH's intake.

Does the client have Income from any source?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	Total Monthly Income: \$ _____
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If yes, check all that apply and include amount per month:

\$ _____ Alimony or other spousal support	\$ _____ SSI
\$ _____ Child support	\$ _____ SSDI
\$ _____ Earned income	\$ _____ TANF
\$ _____ General Assistance	\$ _____ Unemployment Insurance
\$ _____ Other: _____	\$ _____ VA non-service connected disability pension
\$ _____ Pension or retirement income	\$ _____ VA service connected disability compensation
\$ _____ Private disability insurance	\$ _____ Worker's Compensation
\$ _____ Retirement income from social security	

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NON-CASH BENEFIT INFORMATION

Does the client have Non-Cash Benefits from any source?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
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If yes, check all that apply and include amount per month:

\$_____ SNAP	\$_____ TANF Child Care Services	\$_____ Other TANF-Funded Services
\$_____ WIC	\$_____ TANF Transportation Services	\$_____ Other: _____

Employed?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
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If no, why not?

<input type="checkbox"/> Looking for work	<input type="checkbox"/> Unable to work	<input type="checkbox"/> Not looking for work
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If yes, what type of employment?

<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Seasonal/sporadic (including day labor)
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Connection with SOAR?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
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Do you currently have a Diversion/Dependency Case Manager with DCF? (Note: verified by DCF)

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data Not Collected
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Please complete one form for each household member at Entry.