FL-507 Central Florida HMIS

Homelessness Prevention 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

☐ Full Name Reported	☐ Partial, Street, or Code Name Reported	☐ Client Doesn't Know	☐ Client Refused

Social Security Number _____ -_____ - _____

Social Security Number Data Quality

☐ Full SSN Reported	☐ Approximate or Partial SSN Reported	☐ Client Doesn't Know	☐ Client Refused

Veteran Status

☐ Yes	☐ No	☐ Client Doesn't Know	☐ Client Refused

Relationship to Head of Household

☐ Self	☐ Head of household's spouse or partner	☐ Other: non-relation member
☐ Head of household's child	☐ Head of household's other relation member	

Date of Birth _____ / _____ / _____

Date of Birth Data Quality

☐ Full DOB Reported	☐ Approximate or Partial DOB Reported	☐ Client Doesn't Know	☐ Client Refused

Gender (Select as many as apply)

☐ Female	☐ A gender that is not singularly "Female" or "Male"	☐ Questioning	☐ Client Refused
☐ Male	☐ Transgender	☐ Client Doesn't Know	

Race

☐ American Indian, Alaska Native, or Indigenous	☐ White
☐ Asian or Asian American	☐ Client Doesn't Know
☐ Black, African American, or African	☐ Client Refused
☐ Native Hawaiian or Pacific Islander	

Ethnicity

☐ Hispanic/Latin(a)(o)(x)
☐ Non-Hispanic/Latin(a)(o)(x)
☐ Client Doesn't Know
☐ Client Refused

DISABILITY INFORMATION

Does the client have a Disabling Condition?

☐ Yes	☐ No	☐ Client Doesn't Know	☐ Client Refused

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?	
☐ Alcohol abuse	☐ Yes	☐ No
☐ Chronic health condition	☐ Yes	☐ No
☐ Developmental	☐ Yes	☐ No
☐ HIV/AIDS	☐ Yes	☐ No
☐ Mental Health Disorder	☐ Yes	☐ No
☐ Physical	☐ Yes	☐ No
☐ Substance Use Disorder	☐ Yes	☐ No

HEALTH INSURANCE INFORMATION

Covered by Health Insurance?

☐ Yes	☐ No	☐ Client Doesn't Know	☐ Client Refused

If yes, check all that apply:

☐ Medicaid	☐ COBRA
☐ Medicare	☐ Private Pay Health Insurance
☐ State Children's Health Insurance	☐ State Health Insurance for Adults
☐ VA Medical Services	☐ Indian Health Services Program
☐ Employer-Provided Health Insurance	☐ 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	TRANSITIONAL OR PERMANENT HOUSING SITUATION
☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, or anywhere outside)	☐ Rental by client with VASH subsidy
☐ Emergency shelter, including hotel/motel paid for with an emergency shelter voucher	☐ Rental by client with GPD TIP subsidy
☐ Safe Haven (this is a type of emergency shelter bed - not Safe Haven Family Shelter)	☐ Owned by client, no ongoing housing subsidy
INSTITUTIONAL SITUATION	☐ Rental by client, no ongoing housing subsidy
☐ Jail, prison, or juvenile detention facility	☐ Rental by client with other ongoing housing subsidy
☐ Long-term care facility or nursing home	☐ Owned by client with ongoing housing subsidy
☐ Substance abuse treatment or detox center	☐ Permanent housing for formerly homeless person
☐ Foster care home or foster care group home	☐ Staying or living in a friend's room, apartment, or house
☐ Psychiatric Hospital or other psychiatric facility	☐ Hotel or motel paid for without emergency shelter voucher
☐ Hospital or other residential non-psychiatric medical facility	☐ Residential project or halfway house with no homeless criteria

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

☐ One night or less	☐ One week or more, but less than one month	☐ 90 days or more, but less than one year
☐ Two to six nights	☐ One month or more, but less than 90 days	☐ 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:

☐ One time	☐ Three times	☐ Client doesn't know
☐ Two times	☐ Four or more times	☐ Client refused

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

☐ 1 (this is the 1st month)	☐ 4 months total	☐ 7 months total	☐ 10 months total	☐ More than 12 months
☐ 2 months total	☐ 5 months total	☐ 8 months total	☐ 11 months total	☐ Client doesn't know
☐ 3 months total	☐ 6 months total	☐ 9 months total	☐ 12 months total	☐ 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?

☐ Orange County	☐ Osceola County	☐ Seminole County	☐ Other	☐ N/A

If other county, please specify **COUNTY** and **STATE**:

_____

Clients' Last Permanent Address:

Street Address: _____

City: _____ State: _____ Zip Code: _____

Address Data Quality:

☐ Full Address Reported	☐ Incomplete or Estimated Address	☐ Client Doesn't Know	☐ Client Refused

Last Permanent Address's Start Date: _____

DOMESTIC VIOLENCE INFORMATION

Is Client a Survivor of Domestic Violence?

☐ Yes	☐ No	☐ Client Doesn't Know	☐ Client Refused

If yes, when did experience occur?

☐ Within the past 3 months	☐ 6 to 12 months ago	☐ Client doesn't know
☐ 3 to 6 months ago	☐ More than a year ago	☐ Client refused

If yes, is the client currently fleeing domestic violence?

☐ Yes	☐ No	☐ Client Doesn't Know	☐ Client Refused

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?

☐ Yes	☐ No	☐ Client Doesn't Know	☐ Client Refused

Total Monthly Income: $_____

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	

NON-CASH BENEFIT INFORMATION

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

☐ Yes	☐ No	☐ Client Doesn't Know	☐ Client Refused

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?

☐ Yes	☐ No	☐ Client Doesn't Know	☐ Client Refused

If no, why not?

☐ Looking for work	☐ Unable to work	☐ Not looking for work

If yes, what type of employment?

☐ Full-time	☐ Part-time	☐ Seasonal/sporadic (including day labor)

Connection with SOAR?

☐ Yes	☐ No	☐ Client Doesn't Know	☐ Client Refused

. Do you currently have a Diversion/Dependency Case Manager with DCF? (Note: verified by DCF)

☐ Yes	☐ No	☐ Data Not Collected

Please complete one form for each household member at Entry.