FL-507 Central Florida HMIS

Transitional Housing Data Collection Form – ENTRY ASSESSMENT

Agency/Program: _____ **Assessment Date:** _____

(Complete a separate intake form for each adult and minor in the household).

CLIENT INFORMATION

Enrollment CoC: ___FL-507___

Client Name: First _____ Middle _____ Last _____

Name Data Quality

☐ Full Name Reported	☐ Partial, Street, or Code Name Reported	☐ Client Doesn't Know	☐ Client Prefers Not to Answer

Social Security Number _____ -_____ - _____

Social Security Number Data Quality

☐ Full SSN Reported	☐ Approximate or Partial SSN Reported	☐ Client Doesn't Know	☐ Client Prefers Not to Answer

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	☐ Approx./Partial DOB Reported	☐ Client Doesn't Know	☐ Client Prefers Not to Answer

Race and Ethnicity

☐ American Indian, Alaska Native, or Indigenous	☐ Middle Easter or North African	☐ Client Prefers Not to Answer
☐ Asian or Asian American	☐ Native Hawaiian or Pacific Islander	☐ Data Not Collected
☐ Black, African American, or African	☐ White	
☐ Hispanic/Latina/e/o	☐ Client Doesn't Know	

Additional Race & Ethnicity Detail: _____

Gender (Select as many as apply)

☐ Woman (Girl, if child)	☐ Man (Boy, if child)	☐ Culturally Specific Identity (e.g., Two-Spirit)		☐ Transgender
☐ Non-Binary	☐ Questioning	☐ Different Identity	☐ Client Doesn't Know	☐ Client Prefers Not to Answer

If different identity, please specify: _____

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DISABILITY INFORMATION

Does the client have a Disabling Condition?

☐Yes	☐No	☐Client Doesn't Know	☐Client Prefers Not to Answer

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 Use Disorder	☐Yes	☐No	☐Client Prefers Not to Answer	☐Client Doesn't Know
☐Chronic Health Condition	☐Yes	☐No	☐Client Prefers Not to Answer	☐Client Doesn't Know
☐Developmental Disability	☐ Yes	☐ No	☐ Client Prefers Not to Answer	☐Client Doesn't Know
☐Drug Use Disorder	☐Yes	☐No	☐Client Prefers Not to Answer	☐Client Doesn't Know
☐HIV/AIDS	☐Yes	☐No	☐Client Prefers Not to Answer	☐Client Doesn't Know
☐Mental Health	☐Yes	☐No	☐Client Prefers Not to Answer	☐Client Doesn't Know
☐Physical Disability	☐Yes	☐No	☐Client Prefers Not to Answer	☐Client Doesn't Know

HOMELESS HISTORY QUESTIONS

In which County/City/State did you live prior to your current episode of homelessness?

☐Orange County	☐Osceola County	☐Seminole County	☐Not Applicable
☐City of Orlando	☐City of Kissimmee	☐City of Sanford	☐Other

County, city, state and zip code (including if other)?

_____

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

HOMELESS SITUATION
☐Place not meant for habitation (e.g., a vehicle, an abandoned building, or anywhere outside)
☐Emergency shelter, including hotel/motel paid for with an emergency shelter voucher, host home shelter
☐ Safe Haven (e.g. DV Shelter or Immigration Sanctuary)

INSTITUTIONAL SITUATION
☐Foster care home or foster care group home
☐Hospital or other residential non-psychiatric medical facility
☐Jail, prison, or juvenile detention facility
☐Long-term care facility or nursing home
☐Psychiatric Hospital or other psychiatric facility
☐Substance abuse treatment or detox center
☐ Client Doesn't Know
☐ Client Prefers Not to Answer

TEMPORARY HOUSING SITUATION
☐ Transitional housing for homeless persons (including homeless youth)
☐Residential project or halfway house with no homeless criteria
☐Hotel or motel paid for without emergency shelter voucher
☐ Host home (non-crisis)
☐Staying or living in a friend's room, apartment or house
☐Staying or living in a family member's room, apartment or house
PERMANENT HOUSING SITUATION
☐ Rental by client, no ongoing housing subsidy
☐ Rental by client, with ongoing housing subsidy
☐ Owned by client, with ongoing housing subsidy
☐ Owned by client, no ongoing housing subsidy

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Length of Stay in Prior Living Situation

☐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
☐Client Doesn't Know	☐Client Prefers Not to Answer	

Approximate date homelessness started:

_____ / _____ / _____

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 Prefers Not to Answer

Total # of months the client has been on the street in an emergency shelter, or safe haven in the past 3 years:

☐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	☐ 12months total	☐Client Prefers Not to Answer

HEALTH INSURANCE INFORMATION

Is the client covered by Health Insurance?

☐Yes	☐No	☐Client Doesn't Know	☐Client Prefers to Not Answer

If yes, check all that apply:

☐ Private	☐ Military Insurance
☐ Private -Employer	☐ State Funded
☐Private - Individual	☐Combined Children's Health Insurance/Medicaid
☐ Medicare	☐Indian Health Service (IHS)
☐ Medicaid	☐ Other Public
☐State Children's Health Insurance Program S - CHIP	☐ Health Insurance Obtained through COBRA

DOMESTIC VIOLENCE INFORMATION

Is Client a Victim/Survivor of Domestic Violence?

☐Yes	☐No	☐Client Doesn't Know	☐Client Prefers Not to Answer

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 Prefers Not to Answer

If yes, is the client currently fleeing domestic violence?

☐Yes	☐No	☐Client Doesn't Know	☐Client Prefers Not to Answer

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INCOME INFORMATION

Record income for all adults on separate intake forms.

Does the client have Income from any source?

☐Yes	☐No	☐Client Doesn't Know	☐Client Prefers Not to Answer

If yes, check all that apply and include amount per month:

$_____ Earned Income (e.g. employment income)	$_____ General Assistance
$_____ Unemployment Insurance	$_____ Retirement Income from Social Security
$_____ Supplemental Security Income (SSI)	$_____ Veteran's Pension
$_____ Social Security Disability Income (SSDI)	$_____ Other Pension
$ _____Veteran's Disability Payment	$_____ Child Support
$_____ Private Disability Insurance	$_____ Alimony or Other Spousal Support
$_____ Worker's Compensation	$_____ Other Income
$_____ Temporary Assistance for Needy Families (TANF)	

Total Monthly Income: $_____

NON-CASH BENEFIT INFORMATION

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

☐Yes	☐No	☐Client Doesn't Know	☐Client Prefers Not to Answer

If yes, check all that apply and include amount per month:

☐Supplemental Nutrition Assistance Program (SNAP)	☐Veteran's Administration Medical Services
☐Medicaid	☐TANF Child Care Services
☐Medicare	☐TANF Transportation Services
☐State Children's Health Insurance Program	☐Other TANF-funded Services
☐Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	☐Other Source: ----------

TRANSLATION ASSISTANCE

Translation Assistance Needed?

☐Yes	☐No	☐Client Doesn't Know	☐Client Prefers Not to Answer

If yes, preferred language?

☐American Sign Language	☐Spanish	☐Client Prefers Not to Answer
☐English	☐Different Preferred Language	☐Data Not Collected
☐French	☐Client Doesn't Know	

If different preferred language, please specify: _____