FL-507 Central Florida HMIS

# Supportive Services Only Data Collection Guide – 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:** _____

**Veteran Status**

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

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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 |

**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 | ☐12 months 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, enter the amount per month for each income source:

| | |
|---|---|
| $_____ 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:

| | |
|---|---|
| ☐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: _____