

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

<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 Prefers Not to Answer
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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 Prefers Not to Answer
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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"/> Approx./Partial DOB Reported	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Prefers Not to Answer
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Race and Ethnicity

<input type="checkbox"/> American Indian, Alaska Native, or Indigenous	<input type="checkbox"/> Middle Eastern/North African	<input type="checkbox"/> Client Prefers Not to Answer
<input type="checkbox"/> Asian or Asian American	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Data Not Collected
<input type="checkbox"/> Black, African American, or African	<input type="checkbox"/> White	
<input type="checkbox"/> Hispanic/Latina/e/o	<input type="checkbox"/> Client Doesn't Know	

Additional Race & Ethnicity Detail: _____

Gender (Select as many as apply)

<input type="checkbox"/> Woman (Girl, if child)	<input type="checkbox"/> Man (Boy, if child)	<input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit)	<input type="checkbox"/> Transgender
<input type="checkbox"/> Non-Binary	<input type="checkbox"/> Questioning	<input type="checkbox"/> Different Identity	<input type="checkbox"/> Client Doesn't Know
		<input type="checkbox"/> Client Prefers Not to Answer	

If different identity, please specify: _____

Veteran Status

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Prefers Not to Answer
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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 Prefers Not to Answer
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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 Use Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Prefers Not to Answer <input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Prefers Not to Answer <input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Prefers Not to Answer <input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> Drug Use Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Prefers Not to Answer <input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Prefers Not to Answer <input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Prefers Not to Answer <input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> Physical Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Prefers Not to Answer <input type="checkbox"/> Client Doesn't Know

HOMELESS HISTORY QUESTIONS

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

<input type="checkbox"/> Orange County	<input type="checkbox"/> Osceola County	<input type="checkbox"/> Seminole County	<input type="checkbox"/> Not Applicable
<input type="checkbox"/> City of Orlando	<input type="checkbox"/> City of Kissimmee	<input type="checkbox"/> City of Sanford	<input type="checkbox"/> Other

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

Prior 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, host home shelter
<input type="checkbox"/> Safe Haven (e.g. DV Shelter or Immigration Sanctuary)

INSTITUTIONAL SITUATION

<input type="checkbox"/> Foster care home or foster care group home
<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility
<input type="checkbox"/> Jail, prison, or juvenile detention facility
<input type="checkbox"/> Long-term care facility or nursing home
<input type="checkbox"/> Psychiatric Hospital or other psychiatric facility
<input type="checkbox"/> Substance abuse treatment or detox center
<input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> Client Prefers Not to Answer

TEMPORARY HOUSING SITUATION

<input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)
<input type="checkbox"/> Residential project or halfway house with no homeless criteria
<input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher
<input type="checkbox"/> Host home (non-crisis)
<input type="checkbox"/> Staying or living in a friend's room, apartment or house
<input type="checkbox"/> Staying or living in a family member's room, apartment or house

PERMANENT HOUSING SITUATION

<input type="checkbox"/> Rental by client, no ongoing housing subsidy
<input type="checkbox"/> Rental by client, with ongoing housing subsidy
<input type="checkbox"/> Owned by client, with ongoing housing subsidy
<input type="checkbox"/> Owned by client, no ongoing housing subsidy

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Length of Stay in Prior Living Situation

<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
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> 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:

<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 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:

<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 Prefers Not to Answer

HEALTH INSURANCE INFORMATION

Is the client covered by Health Insurance?

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

<input type="checkbox"/> Private	<input type="checkbox"/> Military Insurance
<input type="checkbox"/> Private -Employer	<input type="checkbox"/> State Funded
<input type="checkbox"/> Private - Individual	<input type="checkbox"/> Combined Children's Health Insurance/Medicaid
<input type="checkbox"/> Medicare	<input type="checkbox"/> Indian Health Service (IHS)
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Other Public
<input type="checkbox"/> State Children's Health Insurance Program S - CHIP	<input type="checkbox"/> Health Insurance Obtained through COBRA

DOMESTIC VIOLENCE INFORMATION

Is Client a Victim/Survivor of Domestic Violence?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Prefers Not to Answer
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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 Prefers Not to Answer

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 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?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Prefers Not to Answer
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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?

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

<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)	<input type="checkbox"/> Veteran's Administration Medical Services
<input type="checkbox"/> Medicaid	<input type="checkbox"/> TANF Child Care Services
<input type="checkbox"/> Medicare	<input type="checkbox"/> TANF Transportation Services
<input type="checkbox"/> State Children's Health Insurance Program	<input type="checkbox"/> Other TANF-funded Services
<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	<input type="checkbox"/> Other Source: <div style="text-align: right;">-----</div>

TRANSLATION ASSISTANCE

Translation Assistance Needed?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Prefers Not to Answer
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If yes, preferred language?

<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Spanish	<input type="checkbox"/> Client Prefers Not to Answer
<input type="checkbox"/> English	<input type="checkbox"/> Different Preferred Language	<input type="checkbox"/> Data Not Collected
<input type="checkbox"/> French	<input type="checkbox"/> Client Doesn't Know	

If different preferred language, please specify: _____