General Instructions

This is the entry form for the Solano County Coordinated Entry System. This form should be filled out for all household members and entered into HMIS accordingly.

Income and benefits collected by minor children in the household should be reported under the head of household. If a household presents as two minor youth, one of the youth should be designated as the head of household.

No question should remain blank at the end of the assessment. The administrator of this intake must ask all questions of the client and mark the appropriate response. Please note that current HMIS policies require that all data be entered into HMIS within three days of acquisition.

If you are confused about how to answer a question, please refer to the HMIS Data Dictionary. If the data dictionary does not answer your question, please reach out to solanoHMIS@homebaseccc.org for assistance.

CLIENT NAME:

DATE ADMINISTERED:

CLIENT RECORD

NAME (first, middle, last name, suffix, e.g., Jr., Sr., III)

In HMIS the "name" field will be created upon record entry and should auto-populate into the Entry Assessment. Use a client's full, legal name whenever possible. Generally, projects do not need to verify that the information provided matches legal documents.

First name _____ *Middle name(s)* _____

Last name _____ *Suffix* _____ *Alias* _____

NAME DATA QUALITY

Street outreach projects may record a project start with limited information about the client and improve on the accuracy and completeness of client data over time. If using a "made up name" for such an initial identification, indicate that here.

☐	Full name reported	☐	Partial, street name, or code name reported	☐	Client doesn't know	☐	Client refused

SOCIAL SECURITY NUMBER AND DATA QUALITY

The Social Security Number is created when the client record is created and should auto-populate into the Entry Assessment. Some projects may serve clients that do not have an SSN. In these cases, select 'Client doesn't know.'

			–			–				

☐	Full SSN reported
☐	Approximate or partial SSN reported
☐	Client doesn't know
☐	Client refused

VETERAN STATUS

This element is based on self-report by the client. A veteran is anyone who has ever been on active duty in the armed forces of the United States, regardless of discharge status or length of service. For the ***Army, Navy, Air Force, Marine Corps,*** *and* ***Coast Guard****, active duty begins when a military member reports to a duty station after completion of training. For the* ***Reserves*** *and* ***National Guard****, active duty is any time spent activated or deployed, either in the United States or abroad. Or Anyone who was disabled in the line of duty during a period of active duty training. Or Anyone who was disabled from an injury incurred in the line of duty or from acute myocardial infarction, a cardiac arrest, or a cerebrovascular accident during a period of inactive duty training.*

☐	Yes	☐	No	☐	Client doesn't know	☐	Client refused

PROJECT START DATE (e.g., 04/25/2020)

The Project Start Date serves as the information date for all data elements collected on this form; all data must be accurate as of this date, regardless of the date collected.

		/			/				
Month			Day			Year			

DEMOGRAPHICS

DATE OF BIRTH

Use 01/01/YEAR and select 'approximate or partial date of birth' if client cannot recall DOB.

		/			/				
Month			Day			Year			

DATE OF BIRTH TYPE

☐	Full date of birth reported
☐	Approximate or partial date of birth reported
☐	Client doesn't know
☐	Client refused

GENDER

☐	Female	☐	Gender Non-Conforming *(i.e.* not exclusively male or female)
☐	Male		
☐	Trans Female (MTF, or male to female)	☐	Client doesn't know
☐	Trans Male (FTM, or female to male)	☐	Client refused

RACE

Clients may report up to two different races. If a client only identifies as one racial category leave the "secondary race" field blank. "Client doesn't know" and "Client refused" should only be selected if no other response is selected. If the client wishes to indicate "Hispanic or Latino," please indicate that in Ethnicity and then select the appropriate race category here.

Race	Primary race	Secondary race
American Indian or Alaska Native	☐	☐
Asian	☐	☐
Black or African American	☐	☐
Native Hawaiian or Other Pacific Islander	☐	☐
White	☐	☐
Client doesn't know	☐	☐
Client refused	☐	☐

ETHNICITY

☐	Non-Hispanic/Non-Latino	☐	Hispanic/Latino	☐	Client doesn't know	☐	Client refused

RELATIONSHIP TO HEAD OF HOUSEHOLD

In a household of a single individual, that person must be identified as the head of household. In multi-person households, one of person must be designated as the head of household and the rest must have their relationship to the head of household recorded. If the group of persons is composed of adults and children, an adult must be indicated as the head of household.

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

DEMOGRAPHICS (CONT.)

PRIMARY LANGUAGE

☐	American Sign Language	☐	French	☐	Lao	☐	Thai
☐	Arabic	☐	German	☐	Mandarin	☐	Vietnamese
☐	Armenian	☐	Hindi	☐	Portuguese	☐	Other
☐	Austronesian	☐	Hmong	☐	Punjabi	☐	Client doesn't know
☐	Cantonese	☐	Japanese	☐	Russian	☐	Client refused
☐	English	☐	Khmer	☐	Spanish	☐	
☐	Farsi	☐	Korean	☐	Tagalog	☐	

If **OTHER**, *specify:* _____

EDUCATION

What is the client's highest level of educational attainment?

☐	Less than grade 5	☐	Some college
☐	Grades 5–6	☐	Associate degree
☐	Grades 7–8	☐	Bachelor's degree
☐	Grades 9–11	☐	Graduate degree
☐	Grade 12 or high school diploma	☐	Vocational certification
☐	School program does not have grade levels	☐	Client doesn't know
☐	GED	☐	Client refused

SEXUAL ORIENTATION

☐	Heterosexual	☐	Lesbian	☐	Questioning or unsure	☐	Client doesn't know
☐	Gay	☐	Bisexual	☐	Other	☐	Client refused

If **OTHER**, *specify:* _____

PHOTO ID

Does the client have a valid driver's license or photo identification?

☐	Yes	☐	No	☐	Client doesn't know	☐	Client refused

CURRENT LIVING SITUATION

START DATE

		/			/				
Month			Day			Year			

END DATE

		/			/				
Month			Day			Year			

INFORMATION DATE

		/			/				
Month			Day			Year			

CURRENT LIVING SITUATION

☐	Place not meant for habitation	☐	Rental by client, with GPD TIP housing subsidy
☐	Emergency shelter, including hotel or motel paid for with emergency shelter voucher or RHY-funded Host Home shelter	☐	Rental by client, with VASH housing subsidy
☐	Safe Haven	☐	Permanent housing (other than RRH) for formerly homeless persons
☐	Foster care home or foster care group home	☐	Rental by client, with RRH of equivalent subsidy
☐	Hospital or other residential non-psychiatric medical facility	☐	Rental by client, with HCV voucher (tenant or project based)
☐	Jail, prison, or juvenile detention facility	☐	Rental by client in a public housing unit
☐	Long-term care facility or nursing home	☐	Rental by client, no ongoing housing subsidy
☐	Psychiatric hospital or other psychiatric facility	☐	Rental by client, with other ongoing housing subsidy
☐	Substance abuse treatment facility or detox center	☐	Owned by client, with ongoing housing subsidy
☐	Residential project or halfway house with no homeless criteria	☐	Owned by client, no ongoing housing subsidy
☐	Hotel or motel paid for without emergency shelter voucher	☐	Other
☐	Transitional housing for homeless persons (including homeless youth)	☐	Worker unable to determine
☐	Host Home (non-crisis)	☐	Client doesn't know
☐	Staying or living in a friend's room, apartment or house	☐	Client refused
☐	Staying or living in a family member's room, apartment or house		

If **OTHER**, *specify:* _____

CURRENT LIVING SITUATION (CONTINUED)

PROVIDER VERIFYING LIVING SITUATION

☐	BayNorth Church of Christ	☐	Mission Samoa
☐	Berkeley Food & Housing Project	☐	Nation's Finest
☐	Caminar, Inc.	☐	Northern California Family Center
☐	Catholic Charities of Yolo-Solano	☐	On the Move
☐	City of Fairfield Homeless Outreach	☐	Resource Connect Solano
☐	City Vallejo Housing Authority	☐	SHELTER, Inc.
☐	Community Action North Bay	☐	Solano County Healthy & Social Services
☐	Edge Community Church	☐	VA of Northern California
☐	Fighting Back Partnership	☐	Vacaville Solano Services
☐	Lutheran Social Services	☐	Volunteers of America

Is the client going to have to leave their current living situation within 14 days?

☐	Yes	☐	No	☐	Client doesn't know	☐	Client refused

If **YES**, *please specify.*	Yes	No	Client doesn't know	Client refused
Has a subsequent residence been identified?	☐	☐	☐	☐
Does the client have resources or support networks to obtain other permanent housing?	☐	☐	☐	☐
Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?	☐	☐	☐	☐
Has the client moved two or more times in the last 60 days?	☐	☐	☐	☐

LOCATION DETAILS: _____

CLIENT LOCATION

The only option for client location in HMIS is "CA-518," which corresponds with the Solano Continuum of Care.

CURRENT LIVING SITUATION (CONTINUED)

LOCATION WHERE CLIENT SLEPT LAST NIGHT

This field asks for the location where the client slept night. Select the location from a list of cities, census-designated places and unincorporated places in Solano County. If the location where the client slept last night was outside Solano County, select the appropriate county or geographic area.

Location	Location where the client slept last night	Location where the client was last housed
Benicia	☐	☐
Birds Landing	☐	☐
Dixon	☐	☐
Fairfield	☐	☐
Green Valley	☐	☐
Rio Visa	☐	☐
Suisun City	☐	☐
Vacaville	☐	☐
Vallejo	☐	☐
Other area in Solano County	☐	☐
Alameda County	☐	☐
Contra Costa County	☐	☐
Napa County	☐	☐
Sacramento County	☐	☐
San Francisco County	☐	☐
Yolo County	☐	☐
Other area in California (outside Solano County)	☐	☐
Other area outside of California	☐	☐

HOUSING STATUS

This field asks when the client is actually in housing. It is possible for a client to enter a project prior to actually taking possession of the unit. This is common when the project is providing housing locator services for the client. Provide the date the client actually takes possession of the unit. If the client has not taken possession of the unit at the time of project entry leave this field blank and provide an update at a later time when the unit becomes available.

Is the client in permanent housing of project entry date?

☐	Yes	☐	No

If **YES**, *what is the housing move-in date?*

		/			/				

If **YES**, *what is the monthly rent or mortgage?*

$					.	0	0

HOMELESS STATUS VERIFICATION

1. TYPE OF PRIOR LIVING SITUATION

What was the situation the client was living in immediately prior to project start?

Adult members of the same household may have different prior living situations

Homeless Situations	
☐	Place not meant for habitation
☐	Emergency shelter, including hotel or motel paid for with emergency shelter voucher
☐	Safe Haven
Institutional Situations	
☐	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 facility or detox center
Transitional & Permanent Housing Situations	
☐	Hotel or motel paid for without emergency shelter voucher
☐	Owned by client, no ongoing housing subsidy
☐	Owned by client, with ongoing housing subsidy
☐	Permanent housing (other than RRH) for formerly homeless persons
☐	Rental by client, no ongoing subsidy
☐	Rental by client, with VASH subsidy
☐	Rental by client, with GPD TIP subsidy
☐	Rental by client, with other ongoing housing subsidy
☐	Residential project or halfway house with no homeless criteria
☐	Staying or living in a family member's room, apartment, or house
☐	Staying or living in a friend's room, apartment, or house
☐	Transitional housing for homeless persons (including homeless youth)
Other	
☐	Client doesn't know
☐	Client refused

Proceed to Question 3

2. LENGTH OF STAY IN PRIOR LIVING SITUATION

How long was the client staying in that place?

If the client moved around, but in the same type of situation, include the total time in that type of situation. If the client moved around from one situation to another, only include the time in the situation selected.

☐	1 night or less
☐	2 to 6 nights
☐	1 week+, but less than 1 month
☐	1 month+, but less than 90 days
☐	90 days, but less than 1 year
☐	1 year or longer
☐	Client doesn't know
☐	Client refused

Proceed to Question 3

☐	1 night or less
☐	2 to 6 nights
☐	1 week+, but less than 1 month
☐	1 month+, but less than 90 days
☐	90 days, but less than 1 year
☐	1 year or longer
☐	Client doesn't know
☐	Client refused

Proceed to Question 3

STOP
Proceed to Disability Status (page 10)

☐	1 night or less
☐	2 to 6 nights
☐	1 week, but less than 1 month
☐	1 month, but less than 90 days
☐	90 days, but less than 1 year
☐	1 year or longer
☐	Client doesn't know
☐	Client refused

STOP
Proceed to Disability Status (page 10)

HOMELESS STATUS VERIFICATION (CONTINUED)

3. DATE THE CLIENT BECAME HOMELESS THIS TIME

When did the client start staying on the streets,* in emergency shelters, or in safe havens this time?

Determine the date of the last time the client had a place to sleep that was not on the streets, in an emergency shelter, or in a safe haven. Breaks in homelessness are allowed to be included in the look back period to calculate the start date only if:

- *The client moved continuously between the streets, shelters, or safe havens. The date would go back as far as the first time they stayed in one of those places; OR*
- *The break in their time on the streets, shelters, or safe havens was less than 7 nights. A break is considered 6 or less consecutive nights not residing in a place not meant for human habitation, in shelter or in a safe haven. The look back time would not be broken by a stay less than 7 consecutive nights; OR*
- *The break in their time on the streets, ES, or SH was less than 90 days in any of the places listed under the header "institutional situations" on the previous page. The look back time would include all of those days (up to 89 days) when looking back for the start date.*

If this is the client's first day on the streets, shelters, or safe havens, enter today's date.

** "The streets" is being used as short-hand for any place unfit for human habitation (a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground).*

		/			/				
Month			Day			Year			

4. NUMBER OF TIMES THE CLIENT HAS BEEN HOMLESS IN THE PAST THREE YEARS

How many times has the client been homeless on the streets, in shelter, or in safe havens in the past three years, including this time?

Count the times a client has been homeless, separated by breaks, in the last three years. A break means at least 7 consecutive nights of not living on the street, in an emergency shelter, or Safe Haven or at least 90 days in any of the places listed under the header "institutional situations" on the previous page.

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

5. TOTAL NUMBER OF MONTHS THE CLIENT HAS BEEN HOMLESS IN THE PAST THREE YEARS

How many months, in total, has the client has been homeless on the street, in an emergency shelter, or Safe Haven over the past three years?

Add the number of months homeless of all the different times the client has spent homeless on the streets, in shelter, or in safe havens in the past three years. Include any time a client spent in an institution for a period of less than 90 days or time spent in permanent or transitional housing for a period of less than 7 days. Responses may be rounded to the next-highest number of full months. The current month, even if a partial month, can be counted as a full month.

☐	One month or less (choose if this is the first time the client has been homeless)		
☐	Between 2 and 12 months ➔	**Enter the total number of months:**	
☐	More than 12 months		
☐	Client doesn't know		
☐	Client refused		

DISABILITIES

Disability elements for HMIS data collections are based on client report. A client is not required to show proof of disability in order to respond "yes" to this question. Programs which require a disability for a client to be eligible for services may further investigate this element.

SUBSTANCE ABUSE

☐	Yes: Alcohol abuse **only**	☐	No
☐	Yes: Drug abuse **only**	☐	Client doesn't know
☐	Yes: Alcohol **and** drug abuse	☐	Client refused

If YES for <u>alcohol abuse</u>, <u>drug abuse</u>, or <u>both alcohol and drug abuse</u>, *is the disability expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently?*

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

IF **YES**, *DISABILITY START DATE*

		/			/				

Month Day Year

NOTE ON DISABILITY

_____

_____

_____

_____

CHRONIC HEALTH CONDITION

☐	Yes	☐	No
☐	No	☐	Client doesn't know

If YES for <u>chronic health condition</u>, *is the disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?*

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

IF **YES**, *DISABILITY START DATE*

		/			/				

Month Day Year

NOTE ON DISABILITY

_____

_____

_____

_____

DEVELOPMENTAL

☐	Yes	☐	No
☐	No	☐	Client doesn't know

If YES for <u>developmental disability</u>, *is the disability expected to substantially impair the client's ability to live independently?*

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

IF **YES**, *DISABILITY START DATE*

		/			/				

Month Day Year

NOTE ON DISABILITY

_____

_____

_____

_____

DISABILITIES (CONTINUED)

HIV/AIDS

☐	Yes	☐	No
☐	No	☐	Client doesn't know

If YES for <u>HIV/AIDS</u>, *is the disability expected to substantially impair the client's ability to live independently?*

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

IF **YES**, *DISABILITY START DATE*

		/			/				
Month			Day			Year			

NOTE ON DISABILITY

_____

_____

_____

_____

MENTAL HEALTH PROBLEM

☐	Yes	☐	No
☐	No	☐	Client doesn't know

If YES for <u>mental health problem</u>, *is the disability expected to be of long-continued and indefinite duration and substantially impairs the client's ability to live independently?*

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

IF **YES**, *DISABILITY START DATE*

		/			/				
Month			Day			Year			

NOTE ON DISABILITY

_____

_____

_____

_____

PHYSICAL

☐	Yes	☐	No
☐	No	☐	Client doesn't know

If YES for <u>physical disability</u>, *is the disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?*

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

IF **YES**, *DISABILITY START DATE*

		/			/				
Month			Day			Year			

NOTE ON DISABILITY

_____

_____

_____

_____

DISABLING CONDITION

A disabling condition is any of the above-indicated disabilities or any other physical, mental, or emotional impairment (including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury) that is expected to be of long–continued and indefinite duration and substantially impair ability to live independently. ***Does the client currently have a disabling condition?***

☐	Yes
☐	No
☐	Client doesn't know
☐	Client refused

INCOME

Record regular, recurrent sources that are current (i.e. not terminated). Income received for a minor member of the household should be recorded under the Head of Household's information. If the client has income, enter the monthly amount received. Answer 'No' for sources that have been terminated, even if they were received in the past.

Does the client have any income from any source?

☐	Yes	☐	No	☐	Client doesn't know	☐	Client refused

If **YES**, *answer 'Yes' or 'No' for each income source.*

Source of income	Receiving income from source?		If YES, date client began receiving income	If YES, monthly amount from source (round to nearest dollar)
Alimony or other spousal support	Yes	☐		$. 0 0
	No	☐		
Child support	Yes	☐		$. 0 0
	No	☐		
Earned income (*i.e.*, employment income)	Yes	☐		$. 0 0
	No	☐		
General Assistance (GA)	Yes	☐		$. 0 0
	No	☐		
Pension or retirement income from a former job	Yes	☐		$. 0 0
	No	☐		
Private Disability Insurance	Yes	☐		$. 0 0
	No	☐		
Retirement Income from Social Security	Yes	☐		$. 0 0
	No	☐		
Social Security Disability Insurance (SSDI)	Yes	☐		$. 0 0
	No	☐		
Supplemental Security Income (SSI)	Yes	☐		$. 0 0
	No	☐		
Temporary Assistance for Needy Families (TANF)	Yes	☐		$. 0 0
	No	☐		
Unemployment Insurance	Yes	☐		$. 0 0
	No	☐		
VA Non-Service-Connected Disability Pension	Yes	☐		$. 0 0
	No	☐		
VA Service-Connected Disability Compensation	Yes	☐		$. 0 0
	No	☐		
Worker's Compensation	Yes	☐		$. 0 0
	No	☐		
Other source (specify): _____	Yes	☐		$. 0 0
	No	☐		
Total monthly income from all sources				$. 0 0

What is the client's income as a percentage of Area Median Income (AMI)?

☐	< 30%	☐	30–50%	☐	> 50%

Does the client have a connection with SSI/SSDI, Outreach, Access, and Recovery (SOAR)?

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

NON-CASH BENEFITS

Only record regular, recurrent sources that are current (i.e. not terminated). Non-cash benefits received for a minor member of the household should be recorded under the Head of Household's information. Answer 'No' for sources that have been terminated, even if they were received in the past.

Does the client have any non-cash benefits from any source?

☐	Yes	☐	No	☐	Client doesn't know	☐	Client refused

If **YES**, *answer 'Yes' or 'No' for each non-cash benefit source.*

Source of Non-Cash Benefit	Receiving source?		If YES, date client began receiving source	If YES, monthly amount from source (round to nearest dollar)
Supplemental Nutrition Assistance Program, (*i.e.* CalFresh or Food Stamps)	Yes	☐		$. 0 0
	No	☐		
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	Yes	☐		$. 0 0
	No	☐		
TANF Child Care services	Yes	☐		$. 0 0
	No	☐		
TANF Transportation Services	Yes	☐		$. 0 0
	No	☐		
Other TANF-Funded Services	Yes	☐		$. 0 0
	No	☐		
Other: _____	Yes	☐		$. 0 0
	No	☐		

HEALTH INSURANCE

Only record regular, recurrent sources that are current (i.e. not terminated). Answer 'No' for sources that have been terminated, even if they were received in the past.

Is the client currently covered by health insurance?

☐	Yes	☐	No	☐	Client doesn't know	☐	Client refused

If **YES**, *answer 'Yes' or 'No' for each health insurance source.*

Source of Health Insurance	Receiving health insurance source?		If YES, date client began receiving source	For HOPWA, specify private pay insurance source, if applicable	For HOPWA, specify reason not covered, if applicable
Medicaid (*i.e.* Medi-Cal)	Yes	☐			
	No	☐			
Medicare	Yes	☐			
	No	☐			
State Children's Health Insurance Program (CHIP)	Yes	☐			
	No	☐			
Veteran's Administration (VA) Medical Services	Yes	☐			
	No	☐			
Employer-Provided Health Insurance	Yes	☐			
	No	☐			
Health insurance obtained through COBRA	Yes	☐			
	No	☐			
Private Pay Health Insurance	Yes	☐			
	No	☐			
State Health Insurance for Adults	Yes	☐			
	No	☐			
Indian Health Services Program	Yes	☐			
	No	☐			
Other: _____	Yes	☐			
	No	☐			

EMPLOYMENT

Is the client employed?

☐	Yes	☐	No	☐	Client doesn't know	☐	Client refused

If **YES**, *specify the type of employment.*

☐	Full-time	☐	Client doesn't know
☐	Part-time	☐	Client refused
☐	Seasonal/sporadic (including day labor)		

If **NO**, *specify the reason the client is not employed.*

☐	Looking for work	☐	Client doesn't know
☐	Unable to work	☐	Client refused
☐	Not looking for work		

DOMESTIC VIOLENCE

Is the client a domestic violence victim or survivor?

☐	Yes	☐	No	☐	Client doesn't know	☐	Client refused

If **YES**, *when did the experience occur?*

☐	Within the past three months	☐	One year ago or more
☐	Three to six months ago (excluding six months exactly)	☐	Client doesn't know
☐	Six months to one year ago (excluding one year exactly)	☐	Client refused

If **YES**, *is the client currently fleeing?*

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

COORDINATED ENTRY ASSESSMENT

START DATE / / Month Day Year

END DATE / / Month Day Year

EVENT / / Month Day Year

CURRENT LIVING SITUATION

☐	Caminar: Fairfield	☐	Christian Help Center	☐	CAN-B	☐	General Outreach
☐	Caminar: Vallejo	☐	Church of the Epiphany	☐	Shelter Solano		

ASSESSMENT TYPE

☐	Phone
☐	Virtual
☐	In person

ASSESSMENT LEVEL

☐	Crisis needs assessment
☐	Housing needs assessment

PRIORITIZATION STATUS

☐	Placed on prioritization list
☐	Not placed on prioritization list

COORDINATED ENTRY EVENT

START DATE / / Month Day Year

END DATE / / Month Day Year

EVENT DATE / / Month Day Year

EVENT

☐	Referral to Prevention Assistance Project	☐	Referral to Street Outreach project or services	☐	Referral to Transitional Housing bed/unit opening
☐	Problem Solving/Diversion/Rapid Resolution intervention or service	☐	Referral to Housing Navigation project or services	☐	Referral to Joint TH-RRH project/unit/resource opening
☐	Referral to scheduled Coordinated Entry Crisis Needs Assessment	☐	Referral to non-continuum services: Ineligible for continuum services	☐	Referral to RRH project resource opening
☐	Referral to scheduled Coordinated Entry Housing Needs Assessment	☐	Referral to non-continuum services: No availability in continuum services	☐	Referral to PSH project resource opening
☐	Referral to post-placement/follow-up case management	☐	Referral to Emergency Shelter bed opening	☐	Referral to other PH project/unit/resource opening

If event was **Problem Solving/ Diversion/ Rapid Resolution intervention or service**, *was the client housed or re-housed in a safe alternative?*

☐	Yes
☐	No

If event was **Referral to post-placement/ follow-up case management**, *was the client enrolled in Aftercare project?*

☐	Yes
☐	No

If event was **Referral to an ES, TH, Joint TH-RRH, PSH, or Other PH opening**, *what was the location of the Crisis Housing or Permanent Housing Referral?*

_____

If **YES**, *what was the referral result?*

☐	Successful referral: client accepted
☐	Unsuccessful referral: client rejected
☐	Unsuccessful referral: provider rejected

If **YES**, *what was the referral date?*

/ / Month Day Year

CONTACT INFORMATION

Address _____ *Apt / Unit* _____

City _____ *State* _____ *ZIP Code* _____ *County* _____

County _____

What is the data quality of the client's residence or last permanent address?

☐	Full address reported	☐	Client doesn't know
☐	Incomplete or estimated address reported	☐	Client refused

Phone number _____ *Email address* _____

START DATE

		/			/				
Month			Day			Year			

END DATE (if applicable)

		/			/				
Month			Day			Year			

Landlord's Name _____ *Landlord's Address* _____

Landlord's City _____ *Landlord's State* _____ *Landlord's Phone* _____

EMERGENCY CONTACT

Contact's Name _____ *Contact's Address* _____

Contact's City _____ *Contact's State* _____ *Landlord Phone* _____

Second Phone Number _____ *Relationship to Client* _____

START DATE

		/			/				
Month			Day			Year			

END DATE (if applicable)

		/			/				
Month			Day			Year			