

**INSTRUCTIONS:** Complete this form for the Head of Household (HOH). Complete “Household Member” intake form separately for each additional household member. Paper forms should be stored in the client’s file at the Access Point per CoC regulations. Instructions for the Assessor appear throughout the document in orange.

**ASSESSOR SCRIPT:** *“Today we’re doing an assessment to see if you qualify for assistance with housing in Marion County. Some resources are available for people at risk of experiencing homelessness. Others are for those who are sleeping outside, in a shelter, or fleeing domestic violence. If your situation changes and you find other housing, you may not be eligible for our system resources after that.*

*I’m going to ask you a lot of questions and it is important that you answer honestly to determine what you’re eligible for. Questions are not meant to prevent you from receiving resources. The needs of the community are greater than our resources. This assessment is to help us understand your housing needs, but it is important that you keep looking for other housing options too. Do you want to continue?”*

**BASIC CLIENT INFORMATION: For head of household.** Complete the client’s identifying information. Name and social security number have associated data quality fields. Data quality fields are used to indicate the reason full information wasn’t collected. Name and social security number data quality fields allow users to indicate when a client doesn’t know or refuses to provide information. If the required data is collected then ClientTrack automatically records that full data quality was met.

Assessment date: \_\_\_\_\_ **First Name\*:** \_\_\_\_\_

**Middle Name:** \_\_\_\_\_ **Last Name\*:** \_\_\_\_\_

**Suffix:** \_\_\_\_\_ **Name Quality\*:** Full Name Reported

**SSN:** \_\_\_\_\_

**SSN Quality\*:**  Full SSN     Client Doesn’t Know     Client Prefers Not to Answer

Data Not Collected

**BASIC CLIENT DEMOGRAPHICS: For head of household only**

**Birth Date:** \_\_\_\_\_ **Client Age:** \_\_\_\_\_

**Date of birth quality\*:** Full DOB Reported

**Additional Race and Ethnicity Detail:** \_\_\_\_\_

**Race (choose all that apply) \*:**

<input type="checkbox"/> American Indian, Alaska Native, or Indigenous	<input type="checkbox"/> Hispanic/Latina/e/o
<input type="checkbox"/> Asian or Asian American	<input type="checkbox"/> White
<input type="checkbox"/> Middle Eastern or North African	<input type="checkbox"/> Client doesn’t know
<input type="checkbox"/> Black, African American, or African	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Data not collected

**Gender (choose all that apply)\*:**

- |  |   |
|--|---|
| <input type="checkbox"/> Woman (Girl, if child)                          | <input type="checkbox"/> Questioning                  |
| <input type="checkbox"/> Man (Boy, if child)                             | <input type="checkbox"/> Different Identity           |
| <input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit) | <input type="checkbox"/> Client doesn't know          |
| <input type="checkbox"/> Transgender                                     | <input type="checkbox"/> Client prefers not to answer |
| <input type="checkbox"/> Non-Binary                                      | <input type="checkbox"/> Data not collected           |

**Pronouns (if given):** \_\_\_\_\_

**Sexual Orientation:** \_\_\_\_\_

**Veteran Status\*:** \_\_\_\_\_

**Marital Status:** \_\_\_\_\_

**CONTACT INFORMATION:**

**Address:** \_\_\_\_\_

**City, State, Zip Code:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Primary Phone:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_

**Msg Phone:** \_\_\_\_\_

**CLIENT RELEASE OF INFORMATION & SHARING PLAN (see next page)**

If you are completing a paper assessment because the client has not consented to have their information in HMIS, do not complete the CES ROI.

Instead, complete and file this paper form, then submit the Confidential Intake Form (Inclusion Form) to [CES@chipindy.org](mailto:CES@chipindy.org) for an anonymous CES enrollment.

Otherwise, please complete the following CES ROI and upload a signed copy to Document Check and receive verbal consent to sign electronic ROI in the enrollment workflow.

**Introduction:** This application will be used to help identify your needs and refer you to housing programs. Please understand that the information you provide will be input into the Homeless Management Information System (HMIS), which many homeless service providers in Indianapolis use to keep information about people that they help. Although we will share some of your information for the purposes of helping you connect to resources, we have strict rules about sharing and everyone using HMIS is trained to protect your information. If you do not want to share your information in HMIS, we can complete a confidential application and can still help you connect to resources.

### **SECTION 1 - Identifying Information in HMIS**

**This basic identifying information is collected about you and your family members and can be seen by all Indianapolis agencies that use HMIS:**

- Name
- Gender
- Social security number
- Date of birth
- Race, ethnicity
- Marital status
- Veteran status
- Phone number, address

**Why do we collect information about you?**

- Work with other agencies to help you
- Help case managers work together for you
- Connect you with other helping agencies or benefits you may be eligible for
- Reduce the number of times you have to tell your story
- Identify where there are gaps in our community resources so we can work to fill them

### **SECTION 2 – Coordination of Care Sharing Plan for CES**

Many Indianapolis agencies also use the Coordinated Entry System (CES) to improve services to you through coordination of care. If you receive services from multiple agencies that participate in CES, agreeing to the Sharing Plan defined below allows for these agencies to see your information.

**The information shared about you and your family members through the Coordination of Care Sharing Plan includes the basic identifying information listed in Section 1 and:**

- Homeless status and history
- Type of housing you are eligible for
- Domestic violence history
- Insurance information
- Income information
- Medical information including presence of mental or physical health conditions, disability, substance abuse, pregnancy status

**I understand that:**

\* I can receive a copy of the Privacy Notice/script that explains HMIS and my rights and responsibilities associated with how information is kept and shared through this system, upon request.

\* I understand that the confidentiality of my records is protected by law. I understand that this agency will never give information about me to anyone outside the agency without my specific written consent through a Sharing Plan or as required by law (The regulations are the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR, Parts 160 & 164) and certain Indiana State laws.

\* I understand that the information I provide will be used to determine if I am eligible for partner agency housing, services, or related programs. I also understand that each agency may have different eligibility requirements.

\* I understand that if I have a domestic violence history, details regarding specific incidents will NOT be shared nor will other housing agencies have access to this information unless I have given my consent.

\* I understand that I am signing this consent as a release of information so that my information may be shared with housing providers at housing case conferencing for housing referral and placement purposes. Only relevant information that would impact eligibility will be discussed.

\* I can withdraw my consent to share at any time; however, any information already shared with another agency cannot be taken back. I also understand that the request to discontinue sharing will have to be coordinated between sharing partners. If I withdraw my consent, I should tell any agencies that I see who are included on the Plan.

\* I understand that the refusal to share information in this system will not be used to deny me services such as emergency assistance, outreach, shelter, or housing assistance.

\* I can get a list of the partner agencies that will be able to see my information upon request.

\* I understand that a copy of this authorization is as valid as the original.

**SECTION 3 – Signatures**

**Instructions:** By signing below you understand and agree to all your information being visible to all participating partner agencies according to the Sharing Plan.

***This release is active until revoked.***

Client signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

Signature of guardian or authorized representative (when required): \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Date signed by guardian/authorized representative: \_\_\_\_\_

Assessor signature: \_\_\_\_\_

**HUD PROGRAM ENROLLMENT:** Indy Coordinated Entry

**UNIVERSAL DATA ASSESSMENT:** For head of household only

Assessment Date\*: \_\_\_\_\_ Assessor Name\*: \_\_\_\_\_

- Disabling Condition\*:  Yes  No  Client Doesn't Know  
 Client Prefers Not to Answer  Data Not Collected

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**CLIENT LOCATION:** IN-503 – Indianapolis CoC

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**PRIOR LIVING SITUATION:** Identify the type of residence and length of stay at that residence just prior to (i.e., the night before) program admission.

**Prior living situation\*:**

- Place not meant for habitation  Emergency Shelter  Rental  Transitional Housing  
 Friends  Family  Owned home  Hotel

➤ *If in an institutional situation, also answer:*

- Did you stay less than 90 days?  Yes  No

➤ *If in a transitional or permanent housing situation, also answer:*

- Did you stay less than 7 nights?  Yes  No

**Length of stay in the prior living situation\*:**

- One night or less  
 Two to six nights  
 One week or more but less than one month  
 One month or more but less than 90 days  
 90 days or more but less than one year  
 One year or longer

*Assessor: if household meets HUD's definition of homelessness under Category 1 or 4, complete the following questions. If not, skip them and continue to Health Insurance section.*

Approximate date homelessness started: \_\_\_\_\_

Regardless of where they stayed last night, what is the number of times the client has been on the streets, in ES, or SH in the past three years including today:

- One time  Two times  Three times  Four or more times

Total number of months homeless, on the streets, in ES, or SH in the past three years: \_\_\_\_\_

HEALTH INSURANCE (choose all that apply):

- Private
- Private- Individual
- Private – Employer
- Health insurance obtained through COBRA
- Medicare
- Medicaid
- State Children’s Health Insurance Program (S-CHIP)
- Military Insurance
- Other Public
- State Funded
- Combined Children’s Health Insurance / Medicaid Program
- Indian Health Service (HIS)
- Other
- No Insurance

CRISIS NEEDS ASSESSMENT/TRIAGE ASSESSMENT

Assessor: If current living situation is an institution or transitional or permanent housing, ask the following – otherwise, skip to question 2:

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

- Yes
- No
- Client Doesn’t Know
- Client Prefers Not to Answer
- Data Not Collected

Assessor: if yes, answer the following. If no, skip to question 2:

a. Has a subsequent residence been identified?

- Yes
- No
- Client Doesn’t Know
- Client Prefers Not to Answer
- Data Not Collected

b. Does individual or family have resources or support networks to obtain other permanent housing?

- Yes
- No
- Client Doesn’t Know
- Client Prefers Not to Answer
- Data Not Collected

c. Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?

- Yes
- No
- Client Doesn’t Know
- Client Prefers Not to Answer
- Data Not Collected

d. Has the client moved 2 or more times in the last 60 days?

- Yes
- No
- Client Doesn’t Know
- Client Prefers Not to Answer
- Data Not Collected

2. Is the individual or family either fleeing or attempting to flee domestic violence, has no other residence and lacks the resources and support networks needed to obtain other permanent housing; or is fleeing while remaining in their current place of residence but lacks the resources

**and support networks needed to obtain other permanent housing?** Domestic violence includes dating violence, sexual assault, stalking, trading sex for housing (survival sex), trafficking (forced or coerced into sexual or labor activities), violence or threats of violence because of sexual orientation or gender identity or other dangerous or life-threatening conditions that relate to violence against the individual or family member, including a child, that has taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return or stay in their home:

- Yes       No       Client Doesn't Know       Client Prefers Not to Answer
- Data Not Collected

**Assessor: if yes, answer the following; otherwise, skip to the next question:**

**a. When did the domestic violence experience occur?**

- Within the past 3 months       Three to six months       Six months to one year ago
- One year ago or more       Client Doesn't Know
- Client Prefers Not to Answer       Data Not Collected

**b. Is the client currently fleeing domestic violence, or attempting to do so? This includes situations where they are homeless due to actively fleeing or attempting to flee intimate partner violence, sexual assault, stalking or other dangerous or life threatening conditions related to violence against them or their family:**

- Yes       No       Client Doesn't Know       Client Prefers Not to Answer
- Data Not Collected

**Assessor: if client is age 16-24, please complete the following. Otherwise, skip to the orange box.**

1. Are you interested in being referred to a host home project?  Yes       No
2. Are you currently in foster care or connected to the Department of Child Services, or were you in the past?  Yes       No



**Assessor: You have completed the crisis needs assessment. Continue with the remainder of the assessment if the client is:**

- Literally homeless (currently staying in a place not meant for habitation, an emergency shelter, the Anthem Save Haven, a hotel or motel paid for by a non-profit agency or the government)
- Fleeing or attempting to flee DV
- Currently in or about to enter transitional housing or a YHDP Host Home

**OTHERWISE, STOP THE ASSESSMENT HERE and refer the client to community resources as needed.**

Complete the following section if client identifies as a veteran. Otherwise, skip to Barriers Assessment

**VETERAN ASSESSMENT**

**Branch and Discharge status:** Please select the branch and discharge status. The HMIS Data Manual provides the following instructions for veterans serving in more than one branch: “For veterans who served in more than one branch of the military, select the branch in which the veteran spent the most time. In the event that a client’s discharge status is upgraded during enrollment, the record should be edited to reflect the change.”

**Branch of the military\*:**  Army     Air Force     Navy     Marines     Coast Guard  
 Client doesn’t know

**Discharge status\*:**  Honorable     General under honorable conditions     Under other than honorable conditions (OTH)     Bad conduct     Dishonorable     Uncharacterized     Client doesn’t know

**Military Service Dates:** In the interest of data quality ClientTrack provides date fields and encourages users to enter exact dates if possible. If not, use the first of the year or another standard date determined by your organization. For HMIS purposes, ClientTrack will always calculate years of military service only using year.

**Service entry date\*:** \_\_\_\_\_ **Service exit date:** \_\_\_\_\_

**Please select theatre(s) of operations(s): Circle all that apply**

- Theatre of Operations: World War II
- Theatre of Operations: Vietnam War
- Theatre of Operations: Persian Gulf War (Operation Desert Storm)
- Theatre of Operations: Afghanistan (Operation Enduring Freedom)
- Theatre of Operations: Iraq (Operation Iraqi Freedom)
- Theatre of Operations: Iraq (Operation New Dawn)
- Theatre of Operations: Other Peace-Keeping Operations or Military Interventions (such as Lebanon, Panama, Somalia, Bosnia, Kosovo)
- Theatre of Operations: Korean War

BARRIERS/SPECIAL NEEDS		
<b>ALCOHOL ABUSE</b>		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes:</i>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:
<b>CHRONIC HEALTH CONDITION</b> (defined as a diagnosed condition that is more than 3 months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance)		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes:</i>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:
<b>DEVELOPMENTAL DISABILITY</b>		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes:</i>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:
<b>DRUG ABUSE</b>		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes:</i>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:
<b>HIV/AIDS</b>		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes:</i>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:
<b>MENTAL HEALTH</b>		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes:</i>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:
<b>OTHER</b>		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes:</i>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:
<b>PHYSICAL DISABILITY</b>		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes:</i>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:
<b>FELONY CONVICTION</b>		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes:</i>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:
<b>HISTORY OF FOSTER CARE</b>		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes:</i>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:

**INCOME. Indicate below the client’s sources of MONTHLY income, non-cash benefits, and expenses. The following instructions are quoted from the HMIS Data Manual:**

- When a client has income, but does not know the exact amount, a “Yes” response should be recorded for both the overall income question and the specific source, and the income amount should be estimated.
- Income received by or on behalf of a minor child should be recorded as part of household income under the Head of Household, unless the federal funder in the HMIS Program Specific Manual instructs otherwise. Income should be recorded at the client-level for heads of household and adult household members. Projects may choose to collect this information for all household members including minor children, as long as this does not interfere with accurate reporting per funder requirements. Projects collecting data through client interviews should ask clients whether they receive income from each of the sources listed rather than asking them to state the sources of income they receive.
- Income data should be recorded only for sources of income that are current as of the information date (i.e. have not been specifically terminated). As an example, if a client’s employment has been terminated and the client has not yet secured additional employment, the response for Earned income would be “No.” As a further example, if a client’s most recent paycheck was 2 weeks ago from a job in which the client was working full time for \$15.00/hour, but the client is currently working 20 hours per week for \$12.00 an hour, record the income from the job the client has at the time data are collected (i.e. 20 hours at \$12.00 an hour).

<input type="checkbox"/> <b>ALIMONY</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>CHILD SUPPORT</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>EMPLOYMENT</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>OTHER INCOME</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>PRIVATE DISABILITY INSURANCE</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>SOCIAL SECURITY</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>SOCIAL SECURITY DISABILITY</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>SUPPLEMENTAL SECURITY INCOME</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>TANF</b>		

<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>UNEMPLOYMENT BENEFITS</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>VETERAN BENEFITS</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>VETERAN'S DISABILITY</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>VETERAN'S PENSION</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>WORKER COMPENSATION BENEFITS</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>PENSION OR RETIREMENT INCOME FOR A FORMER JOB</b>		
<i>If yes:</i>	Description:	Monthly amount:

**NON-CASH BENEFITS: Choose all that apply**

<input type="checkbox"/> <b>FOOD STAMPS</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>HEALTHY INDIANA PLAN</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>HOOSIER HEALTHWISE</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>MEDICAID</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>MEDICARE</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>OTHER NON-CASH BENEFITS</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>PRIVATE HEALTH INSURANCE</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>SECTION 8, PUBLIC HOUSING, OR OTHER RENTAL ASSISTANCE</b>		
<i>If yes:</i>	Description:	Monthly amount:

<input type="checkbox"/> <b>SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>STATE CHILDREN’S HEALTH INSURANCE PROGRAM</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>TEMPORARY RENTAL ASSISTANCE</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>VETERAN’S HEALTH CARE</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>WISHARD ADVANTAGE</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>TANF CHILD CARE SERVICES</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>TANF TRANSPORTATION SERVICES</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>OTHER TANF-FUNDED SERVICES</b>		
<i>If yes:</i>	Description:	Monthly amount:

The next section is the new CE Vulnerability Assessment Tool created and approved by the CE Vulnerability working group. The CE Vulnerability Assessment Tool aims to measure vulnerability as defined by the CoC via the CE Vulnerability working group. Obtain the answers to the following questions using conversation-based and trauma-informed assessing. If you would like additional information or training on conversation-based assessing and trauma-informed care, please reach out to the CES team at [ces@chipindy.org](mailto:ces@chipindy.org).

**CE Vulnerability Assessment Tool**

- Have you ever had a lease or rental agreement in your name?**  
 Yes       No       Client Doesn’t Know       Client Prefers Not to Answer  
 Data Not Collected
  
- In the past 7 years have you ever been in the process of eviction from your home?**  
 Yes       No       Client Doesn’t Know       Client Prefers Not to Answer  
 Data Not Collected

3. **Previously to 24 years of age, did your family experience housing instability, such as: moving frequently due to financial problems, living with another family or relatives (also known as doubling up), living in shelter, living in a hotel/motel, or living in a vehicle?**  
 Yes       No       Client Doesn't Know       Client Prefers Not to Answer  
 Data Not Collected
4. **Does your household include a child under six years old?**  
 Yes       No       Client Doesn't Know       Client Prefers Not to Answer  
 Data Not Collected
5. **Does your household include a person of any age who has a developmental disability, a medical diagnosis, or other condition that requires you to provide a substantial amount of care?**  
 Yes       No       Client Doesn't Know       Client Prefers Not to Answer  
 Data Not Collected
6. **Is anyone in your household pregnant?**  
 Yes       No       Client Doesn't Know       Client Prefers Not to Answer  
 Data Not Collected
7. **Do you have a serious physical health diagnoses or condition that impacts your daily life functioning or requires assistance such as home health aide, palliative care, or terminal illness treatment?**  
 Yes       No       Client Doesn't Know       Client Prefers Not to Answer  
 Data Not Collected
8. **Have you ever spent any time in foster care or kinship care?**  
 Yes       No       Client Doesn't Know       Client Prefers Not to Answer  
 Data Not Collected
9. **Does your mental health impact your daily life functioning?**  
 Yes       No       Client Doesn't Know       Client Prefers Not to Answer  
 Data Not Collected
10. **Have you ever been incarcerated (including correctional facility, detention center, jail, prison, and juvenile justice system involvement)?**  
 Yes       No       Client Doesn't Know       Client Prefers Not to Answer  
 Data Not Collected

11. Have you ever been discriminated against because of your sexual orientation or gender identity?

- Yes     
  No     
  Client Doesn't Know     
  Client Prefers Not to Answer  
 Data Not Collected

12. Have you and/or your family experienced racism or discrimination due to the color of your skin in **two** or more of the following areas:

- **Housing (including racial segregation into poorer neighborhoods)**
- **Employment and/or Education (including school-to-prison pipeline)**
- **By law enforcement/criminal justice system**
- **Child welfare/DCS/ CPS**
- **Healthcare or other social service systems**
- **When shopping or banking**
- **In general in the community**

- Yes     
  No     
  Client Doesn't Know     
  Client Prefers Not to Answer  
 Data Not Collected

13. Have you experienced or witnessed violence in a place where you have lived? (Violence can be physical, sexual, financial, verbal, emotional, or psychological, such as manipulation).

- Yes     
  No     
  Client Doesn't Know     
  Client Prefers Not to Answer  
 Data Not Collected

14. Are you currently experiencing violence on the streets or in a shelter?.

- Yes     
  No     
  Client Doesn't Know     
  Client Prefers Not to Answer  
 Data Not Collected

15. Are you currently attempting to avoid people who have hurt you or want to hurt you? OR Is there someone who would try to hurt you if they know where you were?

- Yes     
  No     
  Client Doesn't Know     
  Client Prefers Not to Answer  
 Data Not Collected

**COORDINATED ENTRY ASSESSMENT**

**INTERVENTIONS:** Please check all interventions that the client is eligible for.

- |  |  |
|--|--|
| <input type="checkbox"/> Short-term housing assistance (Rapid Rehousing) | <input type="checkbox"/> Veteran Rapid Re-Housing (SSVF)                 |
| <input type="checkbox"/> Permanent Supportive Housing (PSH)              | <input type="checkbox"/> Veteran Permanent Supportive Housing (HUD-VASH) |
| <input type="checkbox"/> HVAF ESG RRH                                    | <input type="checkbox"/> VOA Contract                                    |
| <input type="checkbox"/> Veteran Transitional Housing (GPD)              |  |

**ELIGIBILITY**

What is the minimum number of bedrooms required\*? \_\_\_\_\_

Do you have any ADA or accessibility needs\*? \_\_\_\_\_

➤ *If yes*, please provide details: \_\_\_\_\_

Do you need a pet friendly unit\*? \_\_\_\_\_

Are you or anyone in your household currently required to be on the sex offender registry? \*

\_\_\_\_\_ ➤ *If yes*, offender registry duration\*: \_\_\_\_\_

If you are currently fleeing/attempting to flee DV OR your homelessness was caused by DV, approximate date homelessness began: \_\_\_\_\_

Have you or anyone in your household ever been convicted of arson\*?  Yes  No

Have you or anyone in your household ever been convicted of drug-related activity for the production or manufacture of methamphetamine on the premises of federally assisted housing\*?

Yes  No

Additional comments (include information about active court cases or warrants here): \_\_\_\_\_

\_\_\_\_\_

-----End of CES Head of Household Enrollment-----

**Don't forget to complete a "Household Member" form for each additional family member!**