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) *:

☐ American Indian, Alaska Native, or Indigenous
☐ Asian or Asian American
☐ Middle Eastern or North African
☐ Black, African American, or African
☐ Native Hawaiian or Pacific Islander
☐ Hispanic/Latina/e/o
☐ White
☐ Client doesn't know
☐ Client prefers not to answer
☐ Data not collected

Gender (choose all that 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
- ☐ 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 form then submit a CES Confidential Assessment Inclusion Form to CES@chipindy.org for an anonymous CES enrollment. The Inclusion Form and its instructions can be found here under **Homeless Documentation Forms**

Otherwise, please complete the following CES ROI, upload the signed copy to Document Check, and receive verbal consent to sign the 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 CRF, 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

CLIENT LOCATION: IN-503 – Indianapolis CoC

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 feel 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

c. **Lethality Score _____**

☐High Lethality
"Yes" to 1 or more of questions 1-5
☐ Moderate Lethality
"No" to all of the first 5 questions but "yes" to 4 or more of questions 6-14
☐ Low Lethality
"Yes" to 3 or fewer of questions 6-14

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		
ALCOHOL ABUSE		
Barrier present? ☐ Yes ☐No		
If yes:	Condition is indefinite? ☐ Yes ☐No	Explanation:
CHRONIC HEALTH CONDITION (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? ☐ Yes ☐No		
If yes:	Condition is indefinite? ☐ Yes ☐No	Explanation:
DEVELOPMENTAL DISABILITY		
Barrier present? ☐ Yes ☐No		
If yes:	Condition is indefinite? ☐ Yes ☐No	Explanation:
DRUG ABUSE		
Barrier present? ☐ Yes ☐No		
If yes:	Condition is indefinite? ☐ Yes ☐No	Explanation:
HIV/AIDS		
Barrier present? ☐ Yes ☐No		
If yes:	Condition is indefinite? ☐ Yes ☐No	Explanation:
MENTAL HEALTH		
Barrier present? ☐ Yes ☐No		
If yes:	Condition is indefinite? ☐ Yes ☐No	Explanation:
OTHER		
Barrier present? ☐ Yes ☐No		
If yes:	Condition is indefinite? ☐ Yes ☐No	Explanation:
PHYSICAL DISABILITY		
Barrier present? ☐ Yes ☐No		
If yes:	Condition is indefinite? ☐ Yes ☐No	Explanation:
FELONY CONVICTION		
Barrier present? ☐ Yes ☐No		
If yes:	Condition is indefinite? ☐ Yes ☐No	Explanation:
HISTORY OF FOSTER CARE		
Barrier present? ☐ Yes ☐No		
If yes:	Condition is indefinite? ☐ Yes ☐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).

☐ **ALIMONY**		
If yes:	Description:	Monthly amount:
☐ **CHILD SUPPORT**		
If yes:	Description:	Monthly amount:
☐ **EMPLOYMENT**		
If yes:	Description:	Monthly amount:
☐ **OTHER INCOME**		
If yes:	Description:	Monthly amount:
☐ **PRIVATE DISABILITY INSURANCE**		
If yes:	Description:	Monthly amount:
☐ **SOCIAL SECURITY**		
If yes:	Description:	Monthly amount:
☐ **SOCIAL SECURITY DISABILITY**		
If yes:	Description:	Monthly amount:
☐ **SUPPLEMENTAL SECURITY INCOME**		
If yes:	Description:	Monthly amount:
☐ **TANF**		

If yes:	Description:	Monthly amount:
☐ **UNEMPLOYMENT BENEFITS**		
If yes:	Description:	Monthly amount:
☐ **VETERAN BENEFITS**		
If yes:	Description:	Monthly amount:
☐ **VETERAN'S DISABILITY**		
If yes:	Description:	Monthly amount:
☐ **VETERAN'S PENSION**		
If yes:	Description:	Monthly amount:
☐ **WORKER COMPENSATION BENEFITS**		
If yes:	Description:	Monthly amount:
☐ **PENSION OR RETIREMENT INCOME FOR A FORMER JOB**		
If yes:	Description:	Monthly amount:

NON-CASH BENEFITS: Choose all that apply

☐ **FOOD STAMPS**		
If yes:	Description:	Monthly amount:
☐ **HEALTHY INDIANA PLAN**		
If yes:	Description:	Monthly amount:
☐ **HOOSIER HEALTHWISE**		
If yes:	Description:	Monthly amount:
☐ **MEDICAID**		
If yes:	Description:	Monthly amount:
☐ **MEDICARE**		
If yes:	Description:	Monthly amount:
☐ **OTHER NON-CASH BENEFITS**		
If yes:	Description:	Monthly amount:
☐ **PRIVATE HEALTH INSURANCE**		
If yes:	Description:	Monthly amount:
☐ **SECTION 8, PUBLIC HOUSING, OR OTHER RENTAL ASSISTANCE**		
If yes:	Description:	Monthly amount:

☐ SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN		
If yes:	Description:	Monthly amount:
☐ STATE CHILDREN'S HEALTH INSURANCE PROGRAM		
If yes:	Description:	Monthly amount:
☐ TEMPORARY RENTAL ASSISTANCE		
If yes:	Description:	Monthly amount:
☐ VETERAN'S HEALTH CARE		
If yes:	Description:	Monthly amount:
☐ WISHARD ADVANTAGE		
If yes:	Description:	Monthly amount:
☐ TANF CHILD CARE SERVICES		
If yes:	Description:	Monthly amount:
☐ TANF TRANSPORTATION SERVICES		
If yes:	Description:	Monthly amount:
☐ OTHER TANF-FUNDED SERVICES		
If yes:	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.

CE Vulnerability Assessment Tool

1. **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

2. **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.

- ☐ Short-term housing assistance (Rapid Rehousing)
- ☐ Permanent Supportive Housing (PSH)
- ☐ HVAF ESG RRH
- ☐ Veteran Transitional Housing (GPD)
- ☐ Veteran Rapid Re-Housing (SSVF)
- ☐ Veteran Permanent Supportive Housing (HUD-VASH)
- ☐ VOA Contract

_____

ELIGIBILITY

What is the minimum number of bedrooms required*? _____

Housing preference details

Provide location preferences (central or south side) and/or unit preferences (bottom or top floor)

Do you have any ADA or accessibility needs*? _____

- ***If yes*, please provide details: _____**

Do you need a pet friendly unit*? _____

Would you be interested in shared housing, if it were available? _____

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: _____

DV Lethality Score (1-15) _____ **Connected to DV Provider? *If yes*, provide details: _____**

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!