

Collection Point: Entry
Projects/grants: ESG and CoC
Clients who are: Children (under 18, not HoH)

“*” Required Fields

1 Client Demographics

First Name:*		Last Name:*	
Middle Name:		Suffix:	
		HoH: *	

Name Data Quality:*

- Full Name Reported
- Partial, or Street Name
- Client Doesn't Know
- Client Refused
- Data Not Collected

Social Security Number:*

- Full SSN Reported
- Approximate or Partial SSN
- Client Doesn't Know
- Client Refused
- Data Not Collected

Birthdate:

* Reported

- Approximate or Partial DOB
- Client Doesn't Know
- Client Refused
- Data Not Collected

Gender:*

- Male Female
- Transgender Female to Male
- Transgender Male to Female
- Gender Non-Conforming (i.e. not exclusively male or female)
- Client Doesn't Know
- Client Refused
- Data Not Collected

Race:*(Select all that apply)

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Client Doesn't Know
- Client Refused
- Data Not Collected

Ethnicity:*

- Hispanic/Latino
- Non-Hispanic/Latino
- Client Doesn't Know
- Client Refused
- Data Not Collected

If Female, Pregnancy Status:*

- Yes Due Date: _____
- No
- Client Doesn't Know
- Client Refused
- Data Not Collected

Relationship to Head of Household:*

- Self
- Spouse
- Daughter
- Son
- Dependent Child
- Other Family Member
- Other Non-Family Member

Client Contact Information:

Address: _____ City/State/Zip: _____

Email: _____ Home Phone: _____

2 Project Enrollment

Project Start Date:* _____ **Case Manager:** _____

3 Entry Assessment

Disabling Condition:*


- Yes
- No
- Client Doesn't Know
- Client Refused
- Data Not Collected


Covered by Health Insurance: *	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected


If client has Health Insurance, check all that apply below:


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


Identify whether a client has each individual barrier or not.

Alcohol Abuse*	 If "Yes", answer this:	Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?:
<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Data Not Collected

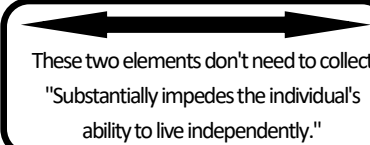
Chronic Health Condition*	 If "Yes", answer this:	Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?:
<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Data Not Collected

Drug Abuse*	 If "Yes", answer this:	Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?:
<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Data Not Collected

Mental Health*	 If "Yes", answer this:	Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?:
<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Data Not Collected

Physical Disability*	 If "Yes", answer this:	Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?:
<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Data Not Collected

Developmental Disability*
<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected


 These two elements don't need to collect
 "Substantially impedes the individual's
 ability to live independently."

HIV/AIDS*
<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected