



# COHMIS

## CoC/ESG Intake Form for Project Types:

Permanent Housing (PSH, PH, RRH), Homelessness Prevention, Transitional Housing, Services Only

<b>SOCIAL SECURITY NUMBER (SSN)</b>									
<b>QUALITY OF SSN</b>		<input type="checkbox"/> Full SSN reported <input type="checkbox"/> Approximate/partial SSN reported				<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected			
<b>CLIENT NAME</b>									
Last:									
First:									
Middle:							Suffix:		
<b>QUALITY OF NAME</b>		<input type="checkbox"/> Full name reported <input type="checkbox"/> Partial, street name, or code name reported				<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected			
<b>DATE OF BIRTH (DOB)</b> (MM/DD/YYYY)									
<b>QUALITY OF DOB</b>		<input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate/partial DOB reported				<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected			
<b>GENDER</b>									
<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Trans Female (MTF or Male to Female) <input type="checkbox"/> Trans Male (FTM or Female to Male) <input type="checkbox"/> Gender Non-Conforming (not exclusively male or female)				<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected			
<b>RACE</b>									
<input type="checkbox"/> White <input type="checkbox"/> Black or African American		<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian				<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected			
<b>ETHNICITY</b>									
<input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino		<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected							
<b>VETERAN STATUS</b>									
<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							
<b>RELATIONSHIP TO HEAD OF HOUSEHOLD</b>									
<input type="checkbox"/> Self (head of household) <input type="checkbox"/> Head of household's child <input type="checkbox"/> Head of household's spouse or partner		<input type="checkbox"/> Head of household's other relation member <input type="checkbox"/> Other: non-relation member							

<b>PROJECT NAME</b>										
<b>PROJECT START DATE</b> (MM/DD/YYYY)										
<b>Has the client ever experienced homelessness before?</b>	<input type="checkbox"/> No		<input type="checkbox"/> Client doesn't know				<input type="checkbox"/> Data not collected			
	<input type="checkbox"/> Yes		<input type="checkbox"/> Client refused							
<b>Housing Move-in Date</b> (PH Only)						<b>Zip Code:</b>				
<b>PRIOR LIVING SITUATION</b> (Where did the client sleep the night before entering this project?) (PICK ONLY 1)										
<b>HOMELESS SITUATION</b>										
<input type="checkbox"/> Place not meant for human habitation (vehicle, anywhere outside) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for w/ emergency shelter voucher or RHY-funded host home <input type="checkbox"/> Safe Haven										
<b>INSTITUTIONAL SITUATION</b>										
<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 facility or detox center										
<b>TRANSITIONAL &amp; PERMANENT HOUSING SITUATION</b>										
<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"/> Transitional housing for homeless persons (including homeless youth) <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 <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with HCV voucher (tenant or project) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected										
<b>LENGTH OF STAY IN PRIOR LIVING SITUATION</b> (How long did the client stay in that situation?)										
<input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected										
<b>If Client's Prior Living Situation is any of the <u>HOMELESS SITUATION</u> options:</b>										
<b>APPROXIMATE DATE HOMELESSNESS STARTED</b> (for the client's <u>current</u> episode of homelessness)										
	MONTH			DAY			YEAR			
<b>Number of times the client has been on the streets, in ES, or Safe Haven in the past three years including today</b> (Regardless of where they stayed last night)										
<input type="checkbox"/> One time <input type="checkbox"/> Two times <input type="checkbox"/> Three times <input type="checkbox"/> Four or more times <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected										
<b>Total number of months homeless on the streets, in ES, or SH in the past three years</b>										
<input type="checkbox"/> One month (first time) <input type="checkbox"/> Two months <input type="checkbox"/> Three months <input type="checkbox"/> Four months <input type="checkbox"/> Five months <input type="checkbox"/> Six months <input type="checkbox"/> Seven months <input type="checkbox"/> Eight months <input type="checkbox"/> Nine months <input type="checkbox"/> Ten months <input type="checkbox"/> Eleven months <input type="checkbox"/> Twelve months <input type="checkbox"/> More than 12 months <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected										

**If Client's Prior Living Situation is any INSTITUTIONAL SITUATION:**

**Length of Stay Less than 90 days?**

*(Indicate if the stay in the Institutional setting they lived in immediately prior to project entry was less than 90 days)*

- No  
 Yes\*

**\*If YES to Length of Stay Less than 90 days**

**On the night before – stayed on the Streets, Emergency Shelter, or Safe Haven?**

*(On the night before the client's stay of less than 90 days in an institutional setting were they on the Streets, in an Emergency Shelter, or in a Safe Haven?)*

- No  
 Yes\*

**\*If YES to 'On the night before – stayed on the Streets, Emergency Shelter, or Safe Haven'**

**APPROXIMATE DATE HOMELESSNESS STARTED**

*(for the client's current episode of homelessness)*

MONTH			DAY			YEAR			

**Number of times the client has been on the streets, in ES, or Safe Haven in the past three years including today** *(Regardless of where they stayed last night)*

- |                                    |                                             |                                              |
|------------------------------------|---------------------------------------------|----------------------------------------------|
| <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 refused      |
|                                    |                                             | <input type="checkbox"/> Data not collected  |

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

- |                                                 |                                       |                                        |                                              |
|-------------------------------------------------|---------------------------------------|----------------------------------------|----------------------------------------------|
| <input type="checkbox"/> One month (first time) | <input type="checkbox"/> Five months  | <input type="checkbox"/> Nine months   | <input type="checkbox"/> More than 12 months |
| <input type="checkbox"/> Two months             | <input type="checkbox"/> Six months   | <input type="checkbox"/> Ten months    | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Three months           | <input type="checkbox"/> Seven months | <input type="checkbox"/> Eleven months | <input type="checkbox"/> Client refused      |
| <input type="checkbox"/> Four months            | <input type="checkbox"/> Eight months | <input type="checkbox"/> Twelve months | <input type="checkbox"/> Data not collected  |

**If Client's Prior Living Situation is any TRANSITIONAL or PERMANENT HOUSING SITUATION:**

**Length of Stay Less than 7 nights?**

*(Indicate if the stay in the Transitional or Permanent Housing setting they lived in immediately prior to project entry was less than 7 nights)*

- No  
 Yes\*

**\*If YES to Length of Stay Less than 7 nights**

**On the night before – stayed on the Streets, Emergency Shelter, or Safe Haven?**

*(On the night before the client's stay of less than 7 nights in a Transitional or Permanent Housing setting, were they on the Streets, in an Emergency Shelter, or in a Safe Haven?)*

- No  
 Yes\*

**\*If YES to 'On the night before – stayed on the Streets, Emergency Shelter, or Safe Haven'**

**APPROXIMATE DATE HOMELESSNESS STARTED**

*(for the client's current episode of homelessness)*

MONTH			DAY			YEAR			

**Number of times the client has been on the streets, in ES, or Safe Haven in the past three years including today** *(Regardless of where they stayed last night)*

- |                                    |                                             |                                              |
|------------------------------------|---------------------------------------------|----------------------------------------------|
| <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 refused      |
|                                    |                                             | <input type="checkbox"/> Data not collected  |

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

- |                                                 |                                       |                                        |                                              |
|-------------------------------------------------|---------------------------------------|----------------------------------------|----------------------------------------------|
| <input type="checkbox"/> One month (first time) | <input type="checkbox"/> Five months  | <input type="checkbox"/> Nine months   | <input type="checkbox"/> More than 12 months |
| <input type="checkbox"/> Two months             | <input type="checkbox"/> Six months   | <input type="checkbox"/> Ten months    | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Three months           | <input type="checkbox"/> Seven months | <input type="checkbox"/> Eleven months | <input type="checkbox"/> Client refused      |
| <input type="checkbox"/> Four months            | <input type="checkbox"/> Eight months | <input type="checkbox"/> Twelve months | <input type="checkbox"/> Data not collected  |

DISABLING CONDITION	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
PHYSICAL DISABILITY	
<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If YES for Physical Disability</b> <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
DEVELOPMENTAL DISABILITY	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
CHRONIC HEALTH CONDITION	
<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If YES for Chronic Health Condition</b> <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
HIV/AIDS	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
MENTAL HEALTH PROBLEM	
<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If YES for Mental Health Problem</b> <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
SUBSTANCE ABUSE PROBLEM	
<input type="checkbox"/> No <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Drug abuse <input type="checkbox"/> Both alcohol and drug abuse	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If YES for Substance Abuse Problem</b> <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

DOMESTIC VIOLENCE VICTIM/SURVIVOR		
	<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
*If YES to Domestic Violence Victim/Survivor		
When did this experience occur?	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago (excluding six months exactly) <input type="checkbox"/> From six to twelve months ago (excluding one year exactly) <input type="checkbox"/> More than a year ago	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Are you currently fleeing?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

CASH INCOME FOR INDIVIDUAL	
Income from Any Source?	<input type="checkbox"/> No <input type="checkbox"/> Yes* <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
*If YES to Income from Any Source – Indicate all sources that apply	
Income Source (Check all that apply)	Monthly Amount
<input type="checkbox"/> Earned Income	
<input type="checkbox"/> Unemployment Insurance	
<input type="checkbox"/> Supplemental Security Income (SSI)	
<input type="checkbox"/> Social Security Disability Insurance (SSDI)	
<input type="checkbox"/> VA Service-Connected Disability Compensation	
<input type="checkbox"/> VA Non-Service Connected Disability Pension	
<input type="checkbox"/> Private Disability Insurance	
<input type="checkbox"/> Worker's Compensation	
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)	
<input type="checkbox"/> General Assistance (GA)	
<input type="checkbox"/> Retirement Income from Social Security	
<input type="checkbox"/> Pension or Retirement Income from a Former Job	
<input type="checkbox"/> Child Support	
<input type="checkbox"/> Alimony and Other Spousal Support	
<input type="checkbox"/> Other Cash Income (Specify: _____)	
<b>Total Monthly Amount</b>	

NON-CASH BENEFITS	
<b>Receiving Non-Cash Benefits?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes* <div style="float: right; text-align: right;"> <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused  <input type="checkbox"/> Data not collected </div>
<b>*If YES to Receiving Non-Cash Benefits – Indicate all sources that apply</b>	
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) <input type="checkbox"/> TANF Transportation Services <input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) <input type="checkbox"/> Other TANF-Funded Services <input type="checkbox"/> TANF Childcare Services <input type="checkbox"/> Other Non-Cash Benefit (Specify source: _____)	

HEALTH INSURANCE	
<b>Covered by Health Insurance?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes* <div style="float: right; text-align: right;"> <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused  <input type="checkbox"/> Data not collected </div>
<b>*If YES to Covered by Health Insurance – Indicate all sources that apply</b>	
<input type="checkbox"/> Medicaid <input type="checkbox"/> Health Insurance Obtained Through COBRA <input type="checkbox"/> Medicare <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Veteran's Administration (VA) Medical Services <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Employer-Provided Health Insurance <input type="checkbox"/> Other Health Insurance (Specify source: _____)	

<b>Would you like to share the reasons or factors you feel contributed to your homelessness?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes*
<b>*If YES please indicate all reasons that apply</b>	
<input type="checkbox"/> Abuse or violence in my home <input type="checkbox"/> Lost a job, could not find work <input type="checkbox"/> Alcohol or substance use problems <input type="checkbox"/> Medical Expenses <input type="checkbox"/> Asked to leave or evicted <input type="checkbox"/> Mental health condition <input type="checkbox"/> Bad credit <input type="checkbox"/> Moved to find work <input type="checkbox"/> Client Choice <input type="checkbox"/> Problems with public benefits <input type="checkbox"/> COVID-19 <input type="checkbox"/> PTSD <input type="checkbox"/> Disabling conditions <input type="checkbox"/> Reasons related to my race or ethnicity <input type="checkbox"/> Discharged from foster care <input type="checkbox"/> Reasons related to my sexual orientation or gender identity <input type="checkbox"/> Discharged from jail <input type="checkbox"/> Relationship problems or family breakup <input type="checkbox"/> Discharged from prison <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Family member or personal illness <input type="checkbox"/> Unable to pay rent or mortgage <input type="checkbox"/> Language barrier <input type="checkbox"/> Unable to pay utilities <input type="checkbox"/> Legal problems <input type="checkbox"/> Other reason (Please specify: _____)	

<b>CONTACT INFORMATION</b> (Optional – entered on the <b>Contacts</b> tab)	
Phone number	
Email	

<b>ADDRESS</b> (Optional – entered on the <b>Locations</b> tab)			
Street			
City			
State		Zip Code	

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Signature of applicant stating all information is true and correct

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Date