ESG Assessment Form
Complete one form for each household member

Today's Date: _____/_____/_____ **Staff Member:** _____

Name:_____
(First) (Last)

Social Security Number:_____-_____-_____ **Birth Date**:_____/_____/_____

Race & Ethnicity
☐ Am Indian, Alaska Native or Indigenous ☐ Asian or Asian American ☐ White
☐ Black, African American, African ☐ Hispanic/Latina/e/o ☐ Middle Eastern or North African
☐ Native Hawaiian or Pacific Islander ☐ Client Doesn't Know ☐ Client Prefers not to answer

Gender:
☐ 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

Veteran Status: ☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client prefers not to answer
Pregnancy Status: ☐ Yes ☐ No If yes, due date: _____

Contact Information: Address: _____
City State Zip

Phone: _____ Message Phone: _____
Email: _____

Relationship to the Head of Household: ☐ Self ☐ Son ☐ Daughter ☐ Dependent Child
☐ Spouse ☐ Other Family Member ☐ Other Non-Family Member

Disabling Condition: Does this member of the household have a disabling condition?
☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client prefers not to answer
If Yes, What type of condition: ☐ Physical ☐ Developmental ☐ Chronic Health Condition
☐ HIV/AIDS ☐ Mental Illness
Currently receiving services for treatment: ☐ Yes ☐ No
Documentation of the disability and its severity on file: ☐ Yes ☐ No

Prior Residence:
☐ Place not meant for habitation (a vehicle, an abandoned building, bus/train/anywhere outside)
☐ Emergency Shelter (including hotel/motel paid for with emergency shelter voucher)
☐ Safe haven
☐ 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 Housing for homeless persons (including homeless youth)
☐ Residential project or halfway house with no homeless criteria
☐ Hotel Paid for without emergency shelter voucher (self pay)
☐ Host Home (non-crisis)
☐ Staying or living in a friend's room, apartment or house

☐ Staying or living in a family member's room, apartment or house
☐ Rental by client, no ongoing housing subsidy
☐ Rental by client, with ongoing housing subsidy
If yes, Rental Subsidy Type:
☐ GPD TIP Housing Subsidy ☐ VASH housing subsidy
☐ RRH or Equivalent subsidy ☐ HCV voucher(not dedicated)
☐ Public housing unit ☐ Emergency Housing Voucher
☐ Rental by client w/other ongoing subsidy ☐ Permanent Supportive Housing
☐ Family Unification Voucher (FUP) ☐ Foster Youth to Independence (FYI)
☐ Other permanent housing formerly homeless
☐ Owned by client, with ongoing housing subsidy
☐ Owned by client, no ongoing housing subsidy
☐ Client Doesn't Know ☐ Client Prefers not to answer

Did you stay less than 7 nights? ☐ Yes ☐ No

Length of Stay: ☐ One night or less ☐ Two to Six nights
☐ More than one week but less than one month
☐ One to three months ☐ More than three months but less than one year
☐ One year or longer ☐ Client Doesn't Know ☐ Prefers not to answer

Approximate Date Homelessness Started: _____/_____/_____

Length of Time on Street, in an Emergency Shelter or Safe Haven – Data in this section are used, along with disabling condition, to determine whether or not a client is chronically homeless.

Regardless of where they stayed last night - Number of times the client has been on the streets, in ES, or SH in the past three years including today:
☐ 0 (Not homeless, prevention only) ☐ 1 (homeless only this time)
☐ 2 ☐ 3 ☐ 4 or more ☐ Client doesn't know ☐ Prefers not to answer

Total number of months homeless on the street, in ES, or SH in the past three years (if answer was 0 Above, Not Homeless, do not complete this section):
☐ One Month (this is the first month) ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
☐ 11 ☐ 12 ☐ More than 12 months ☐ Client Doesn't Know ☐ Client prefers not to answer

Health Insurance Coverage: ☐ Yes ☐ No ☐ Client Doesn't Know ☐ Prefers not to answer
If YES, answer "Yes" or "No" for each health insurance source. (Answer no for sources that have been terminated, even if they were receive in the past)

No	Yes		No	Yes	
☐	☐	Private	☐	☐	Indian Health Service (IHS)
☐	☐	Private – Employer	☐	☐	Other_____
☐	☐	Private - Individual			
☐	☐	Medicare			
☐	☐	Medicaid			
☐	☐	State Children's Health Insurance Program (S-CHIP)			
☐	☐	Military Insurance			
☐	☐	Other Public			
☐	☐	State Funded			
☐	☐	Combined Children's Health Insurance/Medicaid Program			

Barriers – Identify whether a client has each individual barrier.

No	Yes		No	Yes	
☐	☐	Alcohol Abuse	☐	☐	HIV/AIDS
☐	☐	Chronic Health Condition	☐	☐	Mental Illness
☐	☐	Developmental Disability	☐	☐	Physical Disability
☐	☐	Drug Abuse	☐	☐	Other: _____

Domestic Violence Assessment – *If the client has been a victim of domestic violence, select Yes for Domestic Violence Experience and select when the experience occurred.*

Domestic Violence Experienced: ☐ Yes ☐ No ☐ Client Doesn't Know ☐ Prefers not to answer

If Yes, when did the experience occur: ☐ Within past three months ☐ Three to six months ago ☐ Six months to one year ago ☐ One year ago or more ☐ Client Doesn't Know ☐ Client prefers not to answer

Currently Fleeing: ☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client prefers not to answer

Income Information: ☐ Income from Any Source ☐ Non-Cash Benefits

If Yes to Earned Income, type of income:

☐ Earned Income	Mo. Amt: $_____	General Assistance	Mo. Amt: $_____
☐ Unemployment Insurance	Mo. Amt: $_____	Retirement (Soc Sec)	Mo. Amt: $_____
☐ Supplemental Security Income	Mo. Amt: $_____	Veteran's Pension	Mo. Amt: $_____
☐ Social Security Disability Income	Mo. Amt: $_____	Other Pension	Mo. Amt: $_____
☐ Veterans Disability Payment	Mo. Amt: $_____	Child Support	Mo. Amt: $_____
☐ Private Disability Insurance	Mo. Amt: $_____	Alimony	Mo. Amt: $_____
☐ Worker's Compensation	Mo. Amt: $_____	Other Income	Mo. Amt: $_____
☐ TANF	Mo. Amt: $_____		

If Yes to Non-Cash Benefits, type of benefit(s) received:

☐ Food Stamps Monthly Amount: $_____
☐ Medicaid
☐ Medicare
☐ State CHIP
☐ Special Supplemental Nutrition Program for Women, Infants & Children
☐ Veterans Administration Medical Services
☐ TANF Child's Care Service
☐ TANF Transportation Service
☐ Other TANF-funded Services
☐ Other Resources

Translation Assistance Needed: ☐ Yes ☐ No ☐ Client Doesn't Know ☐ Prefers not to answer

If yes, preferred language: _____

Client Signature:_____ Date:_____

Staff Name:_____ Date:_____