ESG-CV Centralized Assessment Intake Form

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

Name:_____
(First) (Last)

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

Gender: ☐ Female ☐ Male ☐ Transgendered Female to Male ☐ Transgendered Male to Female
☐ Gender Non-conforming ☐ Other ☐ Don't Know ☐ Refused

If Female, currently pregnant? ☐ Yes ☐ No If Yes, Due Date: _____/_____/_____

Veteran Status: ☐ No ☐ Yes ☐ Don't Know ☐ Refused
Disabling Condition: ☐ No ☐ Yes ☐ Don't Know ☐ Refused
If Yes, what type of condition: ☐ Physical ☐ Developmental ☐ Chronic
Are you currently receiving services for treatment: ☐ Yes ☐ No
Health Insurance Coverage: ☐ No ☐ Yes ☐ Don't Know ☐ Refused

Marital Status: ☐ Single ☐ Never Married ☐ Divorced
☐ Married & Living with Spouse ☐ Married & Not Living with Spouse
☐ Common Law ☐ Living Together ☐ Widowed ☐ Other ☐ Civil Union

Household Composition:

Names of all Family Members	Relationship to Head of Household	Sex	Date of Birth	Race	Social Security Number

Choices for Relationship to Head of Household: Self (Select this if you are the client applying for services), Husband, Wife, Daughter, Son, Father, Husband & Father, Wife and Mother, Step-daughter, Step-son, Granddaughter, Mother, Grandfather, Grandmother, Grandson, Significant other, Other Relative, Other non-relative, Unknown

Client Contact Information:

Mailing Address:_____
City_____ State_____ Zip Code_____
Home Phone:_____ Mobile Phone_____
Work Phone:_____

Emergency Contact: Name_____

Office Phone: _____ Home Phone:_____

☐ Emergency ☐ Guardian ☐ Other
☐ Relative ☐ Mentor ☐ Physician
☐ Best Friend ☐ Primary Care Giver

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino
☐ Don't Know ☐ Refused

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ White
☐ Native Hawaiian/Other Pacific Islander ☐ Am Indian/Alaskan Native & White
☐ Asian & White ☐ Black/African American & White ☐ Am Indian/Alaskan Native & Black
☐ Other/Balance

Religious Preference: ☐ Protestant ☐ Catholic ☐ Jewish ☐ Islamic
☐ None ☐ Other ☐ Refused

Primary Language: _____

Limited English: ☐ Yes ☐ No

Citizenship Status:

☐ U.S. Citizen ☐ Eligible Non-Citizen ☐ Ineligible Non-Citizen

If client is not a US Citizen, Alien Number and Entry Date (into the United States) is required.

Alien Number: _____ Entry Date: _____/_____/_____

Prior Residence: *Answer Prior Residence and Length of Stay based on the client's living arrangement the night before program entry.*

___ 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 (non-psychiatric)
___ 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
___ Residential project or halfway house with no homeless requirement
___ Hotel or motel paid by self
___ Rental by client, VASH Subsidy
___ Transitional Housing for homeless persons (including homeless youth)
___ Host Home
___ 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 with GPD TIP subsidy
___ Permanent Housing (other than RRH) for formerly homeless person (i.e. SHP, S+C, SRO)

___ Rental by client with RRH or equivalent subsidy
___ Rental by client with HCV Voucher (tenant or project based)
___ Rental by client in a public housing unit
___ Rental by Client, with no ongoing subsidy
___ Rental by client with other ongoing housing subsidy
___ Owned by client, with ongoing subsidy
___ Owned by client, no housing subsidy
___ Client Doesn't Know ___ Client Refused

Length of Stay: _____ One week or less
_____ 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
_____ Don't know
_____ Refused

Housing Status: *Select the client's Housing Status at time of program entry. Only choose literally homeless if client meets the HUD Definition of literally homeless.*

_____ Stably Housed

Homeless: _____ Literally Homeless
_____ At Imminent Risk of Literal Homelessness
_____ At-Risk of Literal Homelessness

Housed: _____ At-Risk of Homelessness

Prior Zip Code: Enter Prior Zip Code for the client's last stable residence of at least 90 days, if known.

Prior Zip Code:_____ City:_____ State:_____

Chronic Homelessness Assessment - *Chronically homeless individual/family. If not applicable skip this section.*

Select the check boxes below that reflect the client's history.

☐ A homeless individual living in a place not meant for human habitation, safe haven or emergency shelter
☐ Continuously Homeless for a Year or More
☐ 4 Episodes of Homelessness in the Past 3 years
☐ Residing in an institutional care facility including jail, substance abuse or mental health treatment facility, hospital or other similar facility for fewer than 90 days & was homeless before entering the facility
☐ A family with an adult head of household who is homeless & the household composition has fluctuated while the head of household has been homeless

Disabling Condition – Indicate if the client has a disabling condition.

☐ Substance Use Disorder
☐ Serious Mental Illness
☐ Developmental Disability
☐ Post-traumatic Stress Disorder
☐ Cognitive Impairments Resulting from Brain Injury
☐ Chronic Physical Illness or Disability

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

If Yes, when did the experience occur:
- ☐ Within the past three months
- ☐ Three to six months ago
- ☐ From six to twelve months ago
- ☐ More than a year ago
- ☐ Don't Know
- ☐ Refused

What Services Are You Requesting?

Housing Relocation & Stabilization Services:
- ☐ Housing Search & Placement
- ☐ Case Management
- ☐ Mediation (between client & landlord)
- ☐ Legal Services
- ☐ Credit Repair

Shelter Operations:
- ☐ Motel/Hotel Voucher

Financial Assistance:
- ☐ Moving Costs
- ☐ Rental Application Fee
- ☐ Security Deposit
- ☐ Last Month's Rent
- ☐ Utility Deposit
- ☐ Utility Payments
- ☐ Utility Arrears (up to 6 months)

Rental Assistance:
- ☐ Short-term (1-3 months)
- ☐ Medium-term (4-24 months)
- ☐ Rental Arrears (up to 6 months)

Reason Assistance Needed:
- ☐ Eviction within 14 days
- ☐ Eviction within 21 days
- ☐ Rental Arrears
- ☐ Utility Disconnection
- ☐ Job Loss/Significant Change in Income
- ☐ Fleeing Domestic Violence
- ☐ Exiting an Institution
- ☐ Exiting Jail/Prison/Juvenile Detention Center
- ☐ Currently Homeless
- ☐ Foreclosure
- ☐ Other:_____

I/We certify that the information provided on this application is accurate and complete to the best of my knowledge. I/We understand that false statements or information are punishable under Federal Law. I/We also understand that false statements or information are grounds for termination of assistance under this program. I/We also understand that if I/we are receiving assistance as a Victim of Domestic Violence and move back in with the abuser, I/we will be terminated from the program.

I/We understand that I/we are to provide any and all information as requested by the Case Manager or Program Manager that the information provided will be subject to verification, that the housing unit I/we are renting is subject to a physical inspection and must meet HUD standards before assistance can be approved. I/We also understand that any approved assistance will be paid directly to the landlord, property manager or utility company and that I/we are responsible for making whatever payments this program determines are my/our responsibility on time and in full each month. I/We also understand the case manager must be notified of any changes in income or other circumstances (e.g. changes in household composition) that affect the eligibility of assistance under this program.

_____	_____
Print Full Name	Print Full Name
_____	_____
Signature	Signature
_____	_____
Date	Date

STAFF USE ONLY:

Client/Household is approved for assistance in the ESG Program? _____ Yes _____ No

If no, please provide reason:_____

Client Classification: _____ Rapid Re-Housing _____ Homeless Prevention

Date of Entry:_____/_____/_____ Staff Member Approving:_____
(please print)

Staff signature:_____ Date:_____