

RRH & HP ESG Centralized Assessment Intake Form

Today's Date: ____/____/____

Staff Member: _____

Name: _____

(First)

(Last)

Social Security Number: ____ - ____ - ____

Birth Date: ____/____/____

- 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), Son, Daughter, Dependent Child, Spouse, Other Family Member, Other Non-family

- 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

Pregnancy Status: Yes No If Yes, Due Date: ____/____/____

Disabling Condition: No Yes

Veteran Status: No Yes Client Doesn't Know Client prefers not to answer

Client Contact Information:

Mailing Address: _____

City _____ State _____ Zip Code _____

Home Phone: _____ Mobile Phone _____

Work Phone: _____

Housing Status: *Select the client's Housing Status at time of program entry.*

Stably Housed – Rent Stably Housed – Own

Homeless: Category 1: Literally Homeless
 Category 2: At Imminent Risk of Literal Homelessness
 Category 3: Homeless only under other federal statutes
 Category 4: Fleeing Domestic Violence

Housed: At-Risk of Homelessness

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

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 Client prefers not to answer

Emergency Contact:

Name _____

Phone: _____

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

Reason Assistance Needed:

- | | |
|--|--|
| <input type="checkbox"/> Eviction within 14 days | <input type="checkbox"/> Fleeing Domestic Violence |
| <input type="checkbox"/> Eviction within 21 days | <input type="checkbox"/> Exiting an Institution |
| <input type="checkbox"/> Rental Arrears | <input type="checkbox"/> Exiting Jail/Prison/Juvenile Detention Center |
| <input type="checkbox"/> Utility Disconnection | <input type="checkbox"/> Currently Homeless |
| <input type="checkbox"/> Job Loss/Significant Change in Income | <input type="checkbox"/> Foreclosure |
| | <input type="checkbox"/> Other: _____ |

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)

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 (Head of Household)

Print Full Name (Spouse/Partner)

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/Denial: ____/____/____ Approved/Denied by: _____
(please print)

Staff signature: _____ Date: _____