



# MSCCoC\_MIS ESG Project Start

Community Alliance for the Homeless | Management Information Systems | Tanyce McCray-Davis | MIS Director/System Admin II  
Off. 901-527-1302 | Cell 901-652-2678 | Email: tanyce@cafh.org

FOR TEXT FIELDS, USE BLOCK LETTERS. OTHERWISE, MARK APPROPRIATE BOXES WITH AN "X". Complete a separate form for each member of the household.

### Date of Data Collection

		/			/				
Month			Day			Year			

### Client ID

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### NAME (first, middle, last name, suffix (e.g., Jr, Sr, III)) [All clients]

First Name:																																					
Middle Name:																																					
Last Name:																																					
Suffix:																																					
Alias:																																					

### Social Security Number: [All clients]

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### Date of Birth: (e.g., 10/23/1978) [All clients]

		/			/						
Month			Day			Year					

### PRIMARY RACE (MORE THAN ONE RACE IS PERMITTED. (ALL CLIENTS) \*PLEASE IDENTIFY THE PRIMARY RACE\*

<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> White
<input type="checkbox"/> Asian	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Client refused
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Other

### Ethnicity (All clients)

<input type="checkbox"/> Non-Hispanic / Non-Latino	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Hispanic / Non-Latino	<input type="checkbox"/> Client refused

### Gender (All clients)

<input type="checkbox"/> Female	<input type="checkbox"/> Gender Non-Conforming (i.e., not exclusively male or female)
<input type="checkbox"/> Male	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Trans Female (MTF or Male to Female)	<input type="checkbox"/> Client refused
<input type="checkbox"/> Trans Male (FTM or Female to Male)	

### Veterans Status (all clients)

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Yes	<input type="checkbox"/> Client refused

**Relationship to Head of Household [All clients]**

<input type="checkbox"/>	Self (Head of Household & Singles)	<input type="checkbox"/>	Head of household's other relation to head of household
<input type="checkbox"/>	Head of household's child	<input type="checkbox"/>	Other: non-relation to head of household
<input type="checkbox"/>	Head of household's spouse or partner	<input type="checkbox"/>	Specify Relation: _____

**DOMESTIC VIOLENCE VICTIM (ALL CLIENTS)**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes
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**If Victim of DV - How Long Ago? (All Clients)**

<input type="checkbox"/>	1 Day to 3 Months	<input type="checkbox"/>	More than a Year
<input type="checkbox"/>	3 Months to 6 Months	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	6 Months to 1 Year	<input type="checkbox"/>	Client refused

**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
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**HOMELESS/CHRONIC HOMELESS INFORMATION**

**Residence Prior to Project Entry?**

<input type="checkbox"/>	Place not meant for habitation	<input type="checkbox"/>	Emergency shelter, including hotel or motel paid for with emergency shelter voucher	<input type="checkbox"/>	Interim Housing
<input type="checkbox"/>	Foster care home or foster care group home	<input type="checkbox"/>	Jail, prison or juvenile detention facility	<input type="checkbox"/>	Psychiatric hospital or other psychiatric facility
<input type="checkbox"/>	Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/>	Long-term care facility or nursing home	<input type="checkbox"/>	Substance abuse treatment facility or detox center
<input type="checkbox"/>	Hotel or motel paid for without emergency shelter voucher	<input type="checkbox"/>	Rental by client, with VASH subsidy	<input type="checkbox"/>	Staying or living in a friend's room, apartment or house
<input type="checkbox"/>	Owned by client, no ongoing housing subsidy	<input type="checkbox"/>	Rental by client, with GPD TIP subsidy	<input type="checkbox"/>	Transitional housing for homeless persons (including homeless youth)
<input type="checkbox"/>	Owned by client, with ongoing housing subsidy	<input type="checkbox"/>	Rental by client, with other ongoing housing subsidy	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Permanent housing for formerly homeless persons (such as: a CoC project; HUD legacy programs; or HOPWA PH)	<input type="checkbox"/>	Residential project or halfway house with no homeless criteria	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Rental by client, no ongoing housing subsidy	<input type="checkbox"/>	Staying or living in a family member's room, apartment or house	<input type="checkbox"/>	Data not collected
<input type="checkbox"/>	VA Medical Referral				

**Length of Stay in Prior Living 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
<input type="checkbox"/>	Unknown				

Approximate date homelessness started:

		/			/				
Month			Day			Year			

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:

<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"/>	Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/>	Long-term care facility or nursing home	<input type="checkbox"/>	Substance abuse treatment facility or detox center

Total number of months homeless on the street, in ES, or SH in the past three years:

<input type="checkbox"/>	One month (this is the first time)	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4
<input type="checkbox"/>	5	<input type="checkbox"/>	6	<input type="checkbox"/>	7	<input type="checkbox"/>	8
<input type="checkbox"/>	9	<input type="checkbox"/>	10	<input type="checkbox"/>	11	<input type="checkbox"/>	12
<input type="checkbox"/>	More than 12	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected

**INCOME & SOURCES \*PROOF NEEDED\***

What is the Household total monthly income?

\$ \_\_\_\_\_

Have you received 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
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If yes for "Income from any source:

Indicate all sources and dollar amounts for the source that apply:

No	Yes	Source of Income	Amount	No	Yes	Source of Income	Amount
<input type="checkbox"/>	<input type="checkbox"/>	Earned income (i.e. employment income)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Worker's Compensation	\$
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Security Income (SSI)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Temporary Assistance for Needy Families (TANF)	\$
<input type="checkbox"/>	<input type="checkbox"/>	Social Security Disability Income (SSDI)	\$	<input type="checkbox"/>	<input type="checkbox"/>	General Assistance (GA)	\$
<input type="checkbox"/>	<input type="checkbox"/>	VA Service Connected Disability Compensation	\$	<input type="checkbox"/>	<input type="checkbox"/>	VA Non Service Connected Disability Pension	\$
<input type="checkbox"/>	<input type="checkbox"/>	Retirement Income from Social Security	\$	<input type="checkbox"/>	<input type="checkbox"/>	Responses Pension or retirement income from a former job	\$
<input type="checkbox"/>	<input type="checkbox"/>	Private disability insurance	\$	<input type="checkbox"/>	<input type="checkbox"/>	Child support	\$
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Insurance	\$	<input type="checkbox"/>	<input type="checkbox"/>	Alimony and other spousal support	\$
<input type="checkbox"/>	<input type="checkbox"/>	Other Source (specify	\$				

**NON-CASH BENEFITS \*PROOF NEEDED\***

Have you received non-cash benefits 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
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If yes for non-cash benefits from any source and dollar amounts for the source that apply:

No	Yes	Source of Benefit	Amount	No	Yes	Source of Benefit	Amount
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	\$
<input type="checkbox"/>	<input type="checkbox"/>	SANF Child Care services (or use local name)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Temporary Assistance for Needy Families (TANF)	\$
<input type="checkbox"/>	<input type="checkbox"/>	TANF transportation services (or use local name)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Other TANF unded Services (or use local name)	\$
<input type="checkbox"/>	<input type="checkbox"/>	Section 8, public housing, or other ongoing rental assistance	\$	<input type="checkbox"/>	<input type="checkbox"/>	Temporary rental assistance	\$
<input type="checkbox"/>	<input type="checkbox"/>	Other Source	\$	If yes to "Other" Source, please specify			

**DISABILITY INFORMATION \*PROOF NEEDED\***

Does client have a 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
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**ALCOHOL ABUSE**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:			/			/			
					Month			Day			Year		

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<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
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Is there Documentation of the disability and severity on file?

<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
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Currently receiving services/treatment for this 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
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**CHRONIC HEALTH CONDITION**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:			/			/			
					Month			Day			Year		

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<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
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Is there Documentation of the disability and severity on file?

<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
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Currently receiving services/treatment for this 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
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**DEVELOPMENTAL DISABILITY**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:			/			/			
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Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<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
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Is there Documentation of the disability and severity on file?

<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
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Currently receiving services/treatment for this 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
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**HIV/AIDS**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:			/			/				
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Month                      Day                      Year

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<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
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Is there Documentation of the disability and severity on file?

<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
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Currently receiving services/treatment for this 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
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**MENTAL HEALTH CONDITION**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:			/			/				
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Month                      Day                      Year

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<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
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Is there Documentation of the disability and severity on file?

<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
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Currently receiving services/treatment for this 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
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**PHYSICAL CONDITION**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:			/			/				
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Month                      Day                      Year

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<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
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Is there Documentation of the disability and severity on file?

<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
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Currently receiving services/treatment for this 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
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**COVERED BY HEALTH INSURANCE?**

<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
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**HEALTH INSURANCE PROVIDERS**

NO	YES		NO	YES	
<input type="checkbox"/>	<input type="checkbox"/>	MEDICAID	<input type="checkbox"/>	<input type="checkbox"/>	Health Insurance obtained through COBRA
<input type="checkbox"/>	<input type="checkbox"/>	MEDICARE	<input type="checkbox"/>	<input type="checkbox"/>	Private Pay Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	State Children's Health Insurance Program (or use local name)	<input type="checkbox"/>	<input type="checkbox"/>	State Health Insurance for Adults (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Veteran's Administration (VA) Medical Services	<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Services Program
<input type="checkbox"/>	<input type="checkbox"/>	Employer - Provided Health Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Other

**OUTREACH**

**Date of Engagement:**

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

**Date of Contact**

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

**Start Date**

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

**End Date:**

**Housing Move In Date**

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			