

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: _____

Last Grade Completed/Highest Grade Completed

<input type="checkbox"/> Less than Grade 5	<input type="checkbox"/> Associates degree
<input type="checkbox"/> Grades 5 - 6	<input type="checkbox"/> Bachelor's degree
<input type="checkbox"/> Grades 7 - 8	<input type="checkbox"/> Graduate degree
<input type="checkbox"/> Grades 9 - 11	<input type="checkbox"/> Vocational certification
<input type="checkbox"/> Grade 12 - High School Diploma	<input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> School Program does not have grade levels	<input type="checkbox"/> Client Refused
<input type="checkbox"/> GED	<input type="checkbox"/> Data Not Collected
<input type="checkbox"/> Some College	

Pregnancy

<input type="checkbox"/> Are you Pregnant?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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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 INFORMATION

Is the client homeless? No Yes

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

CLIENT'S RESIDENCE /LAST PERMANENT ADDRESS

Client's Street Address: _____

Client's Apartment Number: _____

Residence Street Name: _____

Client's City: _____ Client's State: _____ Client's ZIP: _____

Home Phone Number: _____ County of Residence: _____

Reason for Leaving this Residence

- Building Condemned
 Evicted
 Family/Friend Conflict
 Fire _____
 Moved to New Residence
 Overcrowding
 Unable to Pay Rent
 Other

Start Date

		/			/			
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Month Day Year

End Date

		/			/			
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Month Day Year

Landlord's Name _____

Landlord's Address _____

Landlord's City _____ State: _____ Landlord's Phone: _____

Zip Code of Last Permanent Address: _____

INCOME & SOURCES *PROOF NEEDED*

PERCENTAGE OF AMI (SSVF Eligibility):

<input type="checkbox"/> Less than 30%	<input type="checkbox"/> 30% to 50%	<input type="checkbox"/> Greater than 50%
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What is the Household total monthly income?
\$ _____

Have you received income from any source? No Yes

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	\$				

EMPLOYMENT STATUS

Date Information Collected:

		/			/			
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Month Day Year

Employed?

<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 "Employed", Type of Employment

<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Seasonal /sporadic (including day labor)
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If No for "Employed", Why not Employed?

<input type="checkbox"/> Looking for Work	<input type="checkbox"/> Unable to Work	<input type="checkbox"/> Not looking for work
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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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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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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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INSURANCE INFORMATION *PROOF NEEDED*

COVERED BY HEALTH INSURANCE?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information 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

VETERAN INFORMATION *PROOF NEEDED*

DATE ENTERED MILITARY SERVICE

<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			

YEAR SEPARATED FROM MILITARY SERVICE

<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			

Branch of Service

<input type="checkbox"/>	Army
<input type="checkbox"/>	Airforce
<input type="checkbox"/>	Navy
<input type="checkbox"/>	Marines
<input type="checkbox"/>	Coast Guard
<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Client Refused
<input type="checkbox"/>	Data Not Collected

Type of Discharge

<input type="checkbox"/>	Honorable
<input type="checkbox"/>	General Under Honorable Conditions
<input type="checkbox"/>	Under Other than Honorable Conditions
<input type="checkbox"/>	Bad Conduct
<input type="checkbox"/>	Dishonorable
<input type="checkbox"/>	Uncharacterized
<input type="checkbox"/>	Client Doesn't Know
<input type="checkbox"/>	Client Refused
<input type="checkbox"/>	Data Not Collected

War/Conflict	YES	NO	Client Doesn't Know	Client Refused	Data Not Collected
World War II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Korean War	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vietnam War	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persian Gulf War	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afghanistan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iraqi Freedom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iraqi Dawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Peace-keeping Operations or Military Interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Residential 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			

VAMC Station Number: _____

Female Veteran? No Yes

SSVF HP TARGETING CRITERIA

1. Referred by Coordinated Entry or a homeless assistance provider to prevent the household from entering an emergency shelter or transitional housing or from staying in a place not meant for human habitation.
 No Yes
2. Current housing loss expected within:
 0 - 6 Days 7 - 13 Days 14 - 21 Days More than 21 Days
3. Current household income is \$0
 No Yes
4. Annual household gross income amount:
 0 to 14% 15% to 30% than 30%
5. Sudden and significant decrease in cash income (employment and/or cash benefits) AND/OR unavoidable increase in non-discretionary expenses (e.g., rent or medical expenses) in the past 6 months
 No Yes
6. Major change in household composition (e.g., death of family member, separation/divorce from adult partner, birth of new child) in the past 12 months
 No Yes
7. Rental Evictions within the Past 7 Years
 4 or more prior rental evictions
 2 - 3 prior rental evictions
 1 prior rental evictions
 0 prior rental evictions
8. Currently at risk of losing a tenant-based housing subsidy or housing in a subsidized building or unit?
 No Yes
9. History of Literal Homelessness (street/shelter/transitional housing)
 4 or more times or total of at least 12 months in past three years
 2 - 3 times in past three years
 1 times in past three years
 None
10. Head of household with disabling condition (physical health, mental health, substance use) that directly affects ability to secure/maintain housing
 No Yes
11. Criminal record for arson, drug dealing or manufacture, or felony offense against persons or property
 No Yes
12. Registered sex offender
 No Yes
13. At least one dependent child under age 6
 No Yes
14. Single parent with minor child(ren)
 No Yes
15. Household size of 5 or more requiring at least 3 bedrooms (due to age/gender mix)
 No Yes
16. Any Veteran in household served in Iraq or Afghanistan
 No Yes
17. Female Veteran
 No Yes
18. HP applicant total points _____
19. Grantee targeting threshold score _____

20. Number of visits to an emergency room in the past year

- 0
- 3 - 5
- 11 - 20
- Client Don't Know
- Data Not Collected
- 1 - 2
- 6 - 10
- More than 20
- Client Refused

21. Approximate number of nights in jail / prison in the past year

- 0
- 3 - 5
- 11 - 20
- Client Don't Know
- Data Not Collected
- 1 - 2
- 6 - 10
- More than 20
- Client Refused

22. Approximate number of nights spent in an inpatient medical facility in the past year

- 0
- 3 - 5
- 11 - 20
- Client Don't Know
- Data Not Collected
- 1 - 2
- 6 - 10
- More than 20
- Client Refused

Housing Move in Date:

		/			/				
Month			Day			Year			

Connection to SOAR

<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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