MSCCoC_MIS ESG Program 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@cafth.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

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]

			-			-				

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

		/			/				

Month D ay Year

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

☐	American Indian or Alaskan Native	☐	White
☐	Asian	☐	Client doesn't know
☐	Black or African American	☐	Client refused
☐	Native Hawaiian or Other Pacific Islander	☐	Other

Ethnicity (All clients)

☐	Non-Hispanic / Non-Latino	☐	Client doesn't know
☐	Hispanic / Non-Latino	☐	Client refused

Gender (All clients)

☐	Female	☐	Gender Non-Conforming (i.e., not exclusively male or female
☐	Male	☐	Client doesn't know
☐	Trans Female (MTF or Male to Female)	☐	Client refused
☐	Trans Male (FTM or Female to Male)		

Veterans Status (all clients)

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

Client Location: TN-501

Relationship to Head of Household [All clients]

☐	Self (Head of Household & Singles)	☐	Head of household's other relation member
☐	Head of household's child	☐	Other: non-relation member
☐	Head of household's spouse or partner	☐	Specify Relation: _____

L

DOMESTIC VIOLENCE VICTIM (ALL CLIENTS)

☐	No	☐	Yes

If Victim of DV - How Long Ago? (All Clients)

☐	1 Day to 3 Months	☐	More than a Year
☐	3 Months to 6 Months	☐	Client doesn't know
☐	6 Months to 1 Year	☐	Client refused

Are you currently fleeing?

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

HOMELESS INFORMATION

Is the client homeless? ☐ No ☐ Yes **Is the client chronically homeless?** ☐ No ☐ Yes

Homelessness and At-Risk of Homelessness Status

☐	Category 1 - Homeless	☐	Stably Housed
☐	Category 2 - At imminent risk of losing housing	☐	Client doesn't know
☐	Category 3 - Homeless only under other federal statutes	☐	Client refused
☐	Category 4 - Fleeing domestic violence	☐	Data not collected
☐	At-risk of homelessness		

Residence Prior to Project Entry?

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

Length of Stay in Prior Living Situation

☐	One night or less	☐	Two to six nights	☐	One week or more, but less than one month
☐	One month or more, but less than 90 days	☐	90 days or more, but less than one year	☐	One year or longer
☐	Client doesn't know	☐	Client refused	☐	Data not collected
☐	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:

☐	One Time	☐	Two times	☐	Three times
☐	Four or more times	☐	Client doesn't know	☐	Client refused
☐	Hospital or other residential non-psychiatric medical facility	☐	Long-term care facility or nursing home	☐	Substance abuse treatment facility or detox center

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

☐	One month (this is the first time)	☐	2	☐	3	☐	4
☐	5	☐	6	☐	7	☐	8
☐	9	☐	10	☐	11	☐	12
☐	More than 12	☐	Client doesn't know	☐	Client refused	☐	Data not collected

INCOME & SOURCES *PROOF NEEDED*

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
☐	☐	Earned income (i.e. employment income)	$	☐	☐	Worker's Compensation	$
☐	☐	Supplemental Security Income (SSI)	$	☐	☐	Temporary Assistance for Needy Families (TANF)	$
☐	☐	Social Security Disability Income (SSDI)	$	☐	☐	General Assistance (GA)	$
☐	☐	VA Service Connected Disability Compensation	$	☐	☐	VA Non Service Connected Disability Pension	$
☐	☐	Retirement Income from Social Security	$	☐	☐	Responses Pension or retirement income from a former job	$
☐	☐	Private disability insurance	$	☐	☐	Child support	$
☐	☐	Unemployment Insurance	$	☐	☐	Alimony and other spousal support	$
☐	☐	Other Source (specify	$				

NON-CASH BENEFITS *PROOF NEEDED*

Have you received non-cash benefits from any source? ☐No ☐Yes

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

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

DISABILITY INFORMATION *PROOF NEEDED*

Does client have a disability?

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

ALCOHOL ABUSE

☐	No	☐	Yes	Date Information Collected:			/			/				
							Month			Day			Year	

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

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

Is there Documentation of the disability and severity on file?

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

Currently receiving services/treatment for this disability?

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

CHRONIC HEALTH CONDITION

☐	No	☐	Yes	Date Information Collected:			/			/				
							Month			Day			Year	

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

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

Is there Documentation of the disability and severity on file?

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

Currently receiving services/treatment for this disability?

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

DEVELOPMENTAL DISABILITY

☐	No	☐	Yes	Date Information Collected:			/			/				
							Month			Day			**Year**	

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

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

Is there Documentation of the disability and severity on file?

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

Currently receiving services/treatment for this disability?

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

HIV/AIDS

☐	No	☐	Yes	Date Information Collected:			/			/				
							Month			Day			Year	

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

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

Is there Documentation of the disability and severity on file?

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

Currently receiving services/treatment for this disability?

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

MENTAL HEALTH CONDITION

☐	No	☐	Yes	Date Information Collected:			/			/				
							Month			Day			Year	

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

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

Is there Documentation of the disability and severity on file?

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

Currently receiving services/treatment for this disability?

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

PHYSICAL CONDITION

☐	No	☐	Yes	Date Information Collected:			/			/				
							Month			Day			Year	

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

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

Is there Documentation of the disability and severity on file?

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

Currently receiving services/treatment for this disability?

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected

INSURANCE INFORMATION *PROOF NEEDED*

COVERED BY HEALTH INSURANCE?

☐	No	☐	Yes	Date Information Collected:			/			/				

HEALTH INSURANCE PROVIDERS

NO	YES		NO	YES	
☐	☐	MEDICAID	☐	☐	Health Insurance obtained through COBRA
☐	☐	MEDICARE	☐	☐	Private Pay Health Insurance
☐	☐	State Children's Health Insurance Program (or use local name)	☐	☐	State Health Insurance for Adults (or use local name)
☐	☐	Veteran's Administration (VA) Medical Services	☐	☐	Indian Health Services Program
☐	☐	Veteran's Administration (VA) Medical Services	☐	☐	Other
☐	☐	Employer – Provided Health Insurance			

OUTREACH

Date of Engagement:

		/			/				

Month Day Year

Date of Contact

		/			/				

Month Day Year

Start Date

		/			/					

Month Day Year

End Date:

		/			/				

Month Day Year

Housing Move In Date

		/			/				

Month Day Year