

Staff: _____ Project Update Date: ____/____/____ Name of Head of Household: _____

Project Name (Enter Data As): _____

Client RecordClient _____
Name Client ID**Client location as of assessment/review date****i** Select the county in which the client is residing (or sleeping at night if unhoused). This field does not need to match the CoC Code above.

Client Location (County) _____

Health InsuranceCovered by Health Insurance ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

| | | |
|---|-----------------------------|------------------------------|
| Medicaid (MO HealthNet) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Medicare | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| State Children's Health Insurance Program | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Veteran's Health Administration | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Employer-Provided Health Insurance | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Health Insurance obtained through COBRA | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Private Pay Health Insurance | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| State Health Insurance for Adults | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Indian Health Services Program | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Other (specify): _____ | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

i

HUD requires that the client be asked about each individual source of health insurance and requires an answer be recorded for each.

i**Data Entry Tip:**
Remember to end date old records and create new records each time a source of health insurance changes.**Monthly Income**Income from Any Source ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

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

i

HUD requires that the client be asked about each individual source of income and requires an answer be recorded for each. For any income sources where income is received, the monthly amount must also be recorded.

i**Data Entry Tip:**
Remember to end date old records and create new records each time a source of income changes.

Total Monthly Income \$ _____

Non-Cash Benefits

Non-Cash Benefits from Any Source ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Supplemental Nutrition Assistance Program (SNAP)
(Previously known as Food Stamps) ☐ No ☐ Yes

Special Supplemental Nutrition Program for
Women, Infants and Children (WIC) ☐ No ☐ Yes

TANF Child Care services ☐ No ☐ Yes

TANF transportation services ☐ No ☐ Yes

Other TANF-funded services ☐ No ☐ Yes

Other (specify): _____ ☐ No ☐ Yes



HUD requires that the client be asked about each individual source of non-cash benefits and requires an answer be recorded for each.



Data Entry Tip:
Remember to end date old records and create new records each time a source of non-cash benefit changes.

Health

Pregnancy Status ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

If yes, due date ____/____/____

Current Living Situation

Date: ____/____/____

Current living situation (Where is the client staying right now?)

Homeless situations

- ☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
- ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher, host home shelter
- ☐ Safe haven

Skip to next data element.

Institutional situations

- ☐ 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

Skip to "Is client going to have to leave their current living situation within 14 days?"

Temporary housing situations

- ☐ Residential project or halfway house with no homeless criteria
- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Transitional housing for homeless persons (including homeless youth)
- ☐ 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

Skip to "Is client going to have to leave their current living situation within 14 days?"

Permanent housing situations (if none of these options match, skip to "Other")

- ☐ Rental by client, no ongoing housing subsidy
- ☐ Rental by client, with ongoing subsidy ([select subsidy type](#) →)
- ☐ Owned by client, with ongoing housing subsidy
- ☐ Owned by client, no ongoing housing subsidy

If "rental by client, with ongoing subsidy", select type

- ☐ GPD TIP housing subsidy
- ☐ VASH housing subsidy
- ☐ RRH or equivalent subsidy
- ☐ HCV Voucher (tenant or project based)
- ☐ Public housing unit
- ☐ Rental by client, with other ongoing housing subsidy
- ☐ Housing Stability Voucher
- ☐ Family Unification Program Voucher (FUP)
- ☐ Foster Youth to Independence Initiative (FYI)
- ☐ Permanent Supportive Housing
- ☐ Other permanent housing dedicated for formerly homeless persons

Skip to "Is client going to have to leave their current living situation within 14 days?"

Other

- ☐ Other (specify): _____
- ☐ Worker unable to determine

- ☐ Client doesn't know
- ☐ Client prefers not to answer

Is client going to have to leave their current living situation within 14 days?

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

If yes, continue. Otherwise, skip to next data element.

Has a subsequent residence been identified?

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Does individual or family have resources or support networks to obtain other permanent housing?

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Has the client moved 2 or more times in the last 60 days?

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Date of Engagement

i Record the date of the first time the client expressed an interest in working together on a housing plan. This must be on or after the project start date. Leave blank if the client has not yet expressed an interest in working on a housing plan.

Date of Engagement _____/_____/_____

Disabilities

i If one or more of the options below with an asterisk(*) has been selected, the answer to "disabling condition" must be "yes." If none of the answers below with an asterisk(*) has been selected, the answer to "disabling condition" may be "yes" or "no."

| Disability type | Disability determination | If yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? |
|-------------------------------------|---|---|
| Alcohol Use Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA | <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA |
| Both Alcohol and Drug Use Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA | <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA |
| Chronic Health Condition | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA | <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA |
| Developmental Disability | <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA | (not applicable) |
| Drug Use Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA | <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA |
| HIV/AIDS | <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA | (not applicable) |
| Mental Health Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA | <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA |
| Physical Disability | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA | <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA |

DK = Client doesn't know; PNTA = Client prefers not to answer

Domestic Violence

i "Domestic violence" is utilized here as shorthand for domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.

Survivor of Domestic Violence? ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

If yes, when experience occurred

| | |
|--|---|
| <input type="checkbox"/> Within the past three months | <input type="checkbox"/> Three to six months ago |
| <input type="checkbox"/> From six to twelve months ago | <input type="checkbox"/> More than a year ago |
| <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client prefers not to answer |

If yes, currently fleeing? ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer