ESG Assessment Form
Complete one form for each household member

Today's Date: _____/_____/_____ **Staff Member:** _____

Name:_____
(First) (Last)

Social Security Number:_____-_____-_____ **Birth Date**:_____/_____/_____

Ethnicity: ___ Hispanic/Latino ___ Non-Hispanic/Latino ___ Client Doesn't Know ___ Client Refused

Race: ___ American Indian or Alaskan Native ___ Asian ___ Black or African American ___White
___ Native Hawaiian or Other Pacific Islander ___ Client Doesn't Know ___ Client Refused

Gender: ___ Male ___ Female ___ Trans Male (FTM or Female to Male)
___ Trans Female (MTF or Male to Female) ___ Gender Non-conforming
___ Client Doesn't Know ___ Client Refused

Veteran Status: ___ Yes ___ No ___ Client Doesn't Know ___ Client Refused

Contact Information: Address: _____
City State Zip

Phone: _____ Message Phone: _____

Email: _____

Relationship to the Head of Household: ___ Self ___ Son ___ Daughter ___Dependent Child
___ Spouse ___ Other Family Member ___ Other Non-Family Member

Disabling Condition: Does this member of the household have a disabling condition?
___ No ___ Yes ___ Client Doesn't Know ___ Client Refused
If Yes, What type of condition: ___ Physical ___ Developmental ___ Chronic Health Condition
___ HIV/AIDS ___ Mental Illness
Currently receiving services for treatment: ___ Yes ___ No
Documentation of the disability and its severity on file: ___ Yes ___ No

Living Situation: Identify the type of residence and length of stay at that residence just prior to (i.e. the night before) program admission:

___ 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 (non-psychiatric)
___ 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
___ Residential project or halfway house with no homeless requirement
___ Hotel or motel paid by self
___ Rental by client, VASH Subsidy
___ Transitional Housing for homeless persons (including homeless youth)

___ Host Home
___ 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 with GPD TIP subsidy
___ Permanent Housing (other than RRH) for formerly homeless person (i.e. SHP, S+C, SRO)
___ Rental by client with RRH or equivalent subsidy
___ Rental by client with HCV Voucher (tenant or project based)
___ Rental by client in a public housing unit
___ Rental by Client, with no ongoing subsidy
___ Rental by client with other ongoing housing subsidy
___ Owned by client, with ongoing subsidy
___ Owned by client, no housing subsidy
___ Client Doesn't Know ___ Client Refused

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 Refused

Approximate Date Homelessness Started: _____/_____/_____

Length of Time on Street, in an Emergency Shelter or Safe Haven – Data in this section are used, along with disabling condition, to determine whether or not a client is chronically homeless.

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:
___ 0 (Not homeless, prevention only) ___ 1 (homeless only this time)
___ 2 ___ 3 ___ 4 or more ___ Client doesn't know ___ Client refused

Total number of months homeless on the street, in ES, or SH in the past three years (if answer was 0 Above, Not Homeless, do not complete this section):
___ One Month (this is the first month) ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8
___ 9 ___ 10 ___ 11 ___ 12 ___ More than 12 months
___ Client Doesn't Know ___ Client Refused ___ Data Not Collected

Health Insurance Coverage: ___ Yes ___ No ___ Client Doesn't Know ___ Client Refused
If YES, answer "Yes" or "No" for each health insurance source. (Answer no for sources that have been terminated, even if they were receive in the past)

No	**Yes**	
___	___	Private
___	___	Private - Employer
___	___	Private - Individual
___	___	Medicare
___	___	Medicaid
___	___	State Children's Health Insurance Program (S-CHIP)
___	___	Military Insurance
___	___	Other Public
___	___	State Funded
___	___	Combined Children's Health Insurance/Medicaid Program
___	___	Indian Health Services (IHS)
___	___	Other

Barriers – Identify whether a client has each individual barrier.

No	Yes	
___	___	Alcohol Abuse
___	___	Chronic Health Condition
___	___	Developmental Disability
___	___	Drug Abuse
___	___	HIV/AIDS
___	___	Mental Illness
___	___	Physical Disability
___	___	Other:_____

Domestic Violence Assessment – *If the client has been a victim of domestic violence, select Yes for Domestic Violence Experience and select when the experience occurred.*

Domestic Violence Experienced: ___ Yes ___ No ___ Client Doesn't Know ___ Client Refused

If Yes, when did the experience occur: ___ Within the past three months ___ Three to six months ago
___ Six months to one year ago ___ One year ago or more
___ Client Doesn't Know ___ Client Refused

Currently Fleeing: ___ Yes ___ No ___ Client Doesn't Know ___ Client Refused

Income Information: ___ Income from Any Source ___ Non-Cash Benefits

If Yes to Earned Income, type of income:

___ Earned Income	Mo. Amt: $_____	General Assistance	Mo. Amt: $_____
___ Unemployment Insurance	Mo. Amt: $_____	Retirement (Soc Sec)	Mo. Amt: $_____
___ Supplemental Security Income	Mo. Amt: $_____	Veteran's Pension	Mo. Amt: $_____
___ Social Security Disability Income	Mo. Amt: $_____	Other Pension	Mo. Amt: $_____
___ Veterans Disability Payment	Mo. Amt: $_____	Child Support	Mo. Amt: $_____
___ Private Disability Insurance	Mo. Amt: $_____	Alimony	Mo. Amt: $_____
___ Worker's Compensation	Mo. Amt: $_____	Other Income	Mo. Amt: $_____
___ TANF	Mo. Amt: $_____		

If Yes to Non-Cash Benefits, type of benefit(s) received:

___ Food Stamps Monthly Amount: $_____
___ Medicaid
___ Medicare
___ State CHIP
___ Special Supplemental Nutrition Program for Women, Infants & Children
___ Veterans Administration Medical Services
___ TANF Child's Care Service
___ TANF Transportation Service
___ Other TANF-funded Services
___ Other Resources

Client Signature:_____ Date:_____

Staff Name:_____ Date:_____