

ESG Shelter-Only 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

If Female, currently pregnant? Yes No If Yes, Due Date: ____/____/____

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 | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Private |
| <input type="checkbox"/> | <input type="checkbox"/> | Private - Employer |
| <input type="checkbox"/> | <input type="checkbox"/> | Private - Individual |
| <input type="checkbox"/> | <input type="checkbox"/> | Medicare |
| <input type="checkbox"/> | <input type="checkbox"/> | Medicaid |
| <input type="checkbox"/> | <input type="checkbox"/> | State Children's Health Insurance Program (S-CHIP) |
| <input type="checkbox"/> | <input type="checkbox"/> | Military Insurance |
| <input type="checkbox"/> | <input type="checkbox"/> | Other Public |
| <input type="checkbox"/> | <input type="checkbox"/> | State Funded |
| <input type="checkbox"/> | <input type="checkbox"/> | Combined Children's Health Insurance/Medicaid Program |
| <input type="checkbox"/> | <input type="checkbox"/> | Indian Health Services (IHS) |
| <input type="checkbox"/> | <input type="checkbox"/> | 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: _____