

Program Intake/Checkout Form for CoC Grantee Clients

Program Entry Date: _____ Entry Type: HUD-40118 (required for APR)

Name: _____ Birth date: _____

Social Security Number: ()-()-()

SSN Data Quality: Full SSN Reported Partial SSN Reported
 Don't Know or Don't Have SSN Refused

Gender: Female Male Transgender Unknown

Primary Race:

Examples: If a client is *White*, you would select White in Primary Race and White in Secondary Race.

If a client is *Asian & White*, you would select Asian in Primary Race and White in Secondary Race.

American Indian or Alaskan Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander Other Other Multi-Racial White

Secondary Race:

American Indian or Alaskan Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander Other Other Multi-Racial White

Ethnicity: Hispanic/Latino Other (Non Hispanic/Latino)

US Military Veteran: Yes No Don't Know Refused

Is Client Homeless? Yes No

Type of Living Situation:

<input type="checkbox"/> Domestic Violence Situation	<input type="checkbox"/> Own House/Apartment
<input type="checkbox"/> Don't Know	<input type="checkbox"/> Permanent Housing for Formerly Homeless
<input type="checkbox"/> Emergency Shelter	<input type="checkbox"/> Place not meant for habitation
<input type="checkbox"/> Foster care/group home	<input type="checkbox"/> Psychiatric Hospital or Facility
<input type="checkbox"/> Hospital (non-psychiatric)	<input type="checkbox"/> Refused
<input type="checkbox"/> Hotel/Motel without emergency shelter	<input type="checkbox"/> Rental House/Apartment
<input type="checkbox"/> Jail, Prison or Juvenile Facility	<input type="checkbox"/> Subsidized Housing
<input type="checkbox"/> Living with Family	<input type="checkbox"/> Substance Abuse Treatment Center
<input type="checkbox"/> Living with Friends	<input type="checkbox"/> Transitional Housing for Homeless
<input type="checkbox"/> Other	

Length of Stay:

One week or less
 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

Zip Code of Last Permanent Address: _____

Zip Data Quality: Full Zip Code Recorded Don't Know Refused

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Do you have a disability of long duration?

Yes No Don't Know Refused

Disability Type / Special Needs:

(Check all that apply)

- Alcohol Abuse
- Developmental
- Drug abuse
- Dual Diagnosis
- Hearing Impaired
- HIV/AIDS
- Mental Illness
- Other
- Physical/Medical
- Physical/Mobility Limits
- Vision Impaired

Start Date

Note: The start date is required for the disability to be included in the APR. If the actual start date is unknown a date that is prior to the entry date should be entered.

Chronic Homeless Assessment:

An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years. The individual must have been on the streets or in an emergency shelter (not transitional housing) during these episodes.

Is Client Chronically Homeless? Yes No

Income Assessment: See worksheet on page 3

Services (For Provider Use):

Enter all services you are giving the client, with the quantity and value for each. (If you don't charge each service to a grant, leave the value at 0). Use blank lines for services not on the list.

Service Description	Qty	Value	Service Description	Qty	Value
Basic Needs			Representative Payee Services		
Food			Tax Preparation Assistance		
Food Pantries			GED Instruction		
Soup Kitchens			Health Care		
Emergency Shelter			Health Supportive Services		
Transitional Housing/Shelter			Assistive Technology Equipment		
Weatherization			Health Care Referrals		
Rent Payment Assistance			Hygiene		
Rental Deposit Assistance			Alcoholism Counseling		
Homeless Permanent Supportive Housing			Drug Abuse Counseling		
Supportive Housing Placement/Referral			Job Readiness		
Utility Assistance			Job Finding Assistance		
Household Goods			Case/Care Management		
Furniture			Economic Self Sufficiency Programs		
Clothing			Spouse/Domestic Partner Abuse Counseling		
Repair Service			Medical Supplies Donation Programs		
Local Bus Services			Rehabilitative/Habilitative Medicine Associations		
Gas Money / Voucher			Mental Illness/Emotional Disabilities		
Money Management					

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Checkout Information:

Name: _____

Program Exit Date: _____

Reason for Exiting (choose 1):

- Completed program
- Criminal activity / violence
- Death
- Disagreement with rules/persons
- Left for housing opp. before completing program
- Needs could not be met
- Non-compliance with program
- Non-payment of rent
- Other
- Reached maximum time allowed
- Unknown/Disappeared

Destination (choose 1):

- Don't Know
- Emergency Shelter
- Foster care/Foster care group home
- Hospital (non-psychiatric)
- Hotel/motel without emergency shelter
- Jail, Prison/Juvenile detention
- Other
- Own house/apartment
- Permanent housing for formerly homeless (S+C, SHP, etc)
- Places not meant for habitation
- Psychiatric hospital/facility
- Refused
- Rental room/house/apartment
- Staying in a family members room/apartment
- Staying in a friends room/apartment/house
- Substance abuse treatment/detox center
- Transitional housing for homeless

Tenure (choose 1):

- Permanent Transitional Don't Know Refused

Subsidy (choose 1):

- None Public Housing Section 8 S+C HOME Program
 HOPWA Program Other Housing Subsidy Don't Know Refused

Last 30 Day Income: If the last 30 day income is different on exit then it was on entry, a new answer must be added to the Monthly Income sub-assessment.