

Entry Date: _____ Provider/Project Name: _____ Provider # _____

↻ CLIENT Name (first, middle, last, suffix):		↻ Name Data Quality <input type="checkbox"/> Full Name <input type="checkbox"/> Partial, Street or Code Name <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
↻ Social Security Number (SSN)		↻ SSN Data Quality <input type="checkbox"/> Full SSN <input type="checkbox"/> Partial SSN <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
↻ U.S. Military Veteran → Only mark yes if: Served in the United States Armed Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard) or was called into active duty by National Guard or as a Reservist.			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused

↻ Household Type				
<input type="checkbox"/> Single Individual <input type="checkbox"/> Couple with no Children	<input type="checkbox"/> Female Single Parent <input type="checkbox"/> Male Single Parent <input type="checkbox"/> Two Parent Family	<input type="checkbox"/> Non-custodial Caregiver(s) <input type="checkbox"/> Grandparent(s) and Child <input type="checkbox"/> Foster Parent(s)	<input type="checkbox"/> Other	
↻ Relationship to Head of Household (HoH)				
<input type="checkbox"/> Self (head of household) Primary Applicant	<input type="checkbox"/> HoH's spouse/partner <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Significant Other	<input type="checkbox"/> HoH's Child <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Step-child	<input type="checkbox"/> HoH's Other Relative <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other relative <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild	<input type="checkbox"/> HoH's Non-Relation <input type="checkbox"/> Non-relative <input type="checkbox"/> Unrelated Care-giver

↻ Date of Birth (DOB)		Age <input type="text"/>	↻ Gender		Client: <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused
<input type="checkbox"/> Full DOB <input type="checkbox"/> Approx or partial DOB	<input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Trans F to M <input type="checkbox"/> Trans M to F <input type="checkbox"/> Doesn't identify as M, F or Transgender		

↻ Race ✓ one or more and <u>circle</u> primary			↻ Ethnicity		
<input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian / Pacific Islander	<input type="checkbox"/> Native American/Indian <input type="checkbox"/> White	<input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused	

↻ Disabilities (All HH members)	Long Term Condition	Yes	No	Doesn't Know	Refused	Not Collected
Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>				
Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>				
Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>				
Developmental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>				
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>				
Mental Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>				
Physical	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>				
Chronic Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>				

If there are any Long Term Disabilities, Mark "Does the client have a disabling condition" as YES

↻ Client's Current Residence					↻ Client Location <i>is always</i>	
<input type="checkbox"/> Eugene <input type="checkbox"/> Springfield <input type="checkbox"/> Rural LC (non-Metro) <input type="checkbox"/> Other OR County <input type="checkbox"/> Outside OR	OR-500 Eug/Spfgld/Lane Co. CoC					

➤ LIVING SITUATION Residence Prior to the Project Entry Date (generally: Where did you stay last night?)	
Homeless Situations	
<input type="checkbox"/> Place not meant for habitation (street, car, camp, etc) <input type="checkbox"/> Emergency Shelter, including motel vouchers and Egan	<input type="checkbox"/> Interim Housing (Situation where a CH person has been referred to PH project, but is not yet in the unit and is staying elsewhere)
Institutional Situations	
<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital (non-psychiatric) <input type="checkbox"/> Jail, prison or juvenile detention facility	<input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Hotel or motel paid for by client <u>without</u> a voucher <input type="checkbox"/> Substance abuse treatment facility or detox center
Transitional / Permanent Situations	
<input type="checkbox"/> Hotel or motel paid for by client <u>without</u> voucher <input type="checkbox"/> Owned by client, no housing subsidy <input type="checkbox"/> Owned by client, with housing subsidy <input type="checkbox"/> Permanent housing for formerly homeless (ie: Emerald, Camas, 1 st Pl., Housing+, LIFT, Shankle, SPC, Vet LIFT) <input type="checkbox"/> Residential project/halfway house w/ no homeless criteria <input type="checkbox"/> Staying or living in a family member's room, Apt. or house <input type="checkbox"/> Staying or living in a friend's room, apt. or house	<input type="checkbox"/> Rental by client, no housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy (must be Vet) <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with other on-going housing subsidy (i.e.: Section 8, SSVF, Rapid Rehousing, or other Rent Assist Projects) <input type="checkbox"/> Transitional housing for homeless persons (Connections, VA-GPD) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

➤ Length of Stay in Prior Situation	
Less than 90 Days	90 Days or more
<input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> More than a week, less than a month <input type="checkbox"/> One month or more, but less than 90 days	<input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Refused

➤ LENGTH of TIME HOMELESS (Only complete if Prior Residence Situation is <u>Homeless</u> or <u>Institution - Less than 90 Days</u>)	
➤ Approximate date homelessness started:	mm/dd/yyyy
➤ Number of times you have been on the streets or in an emergency shelter in past 3 years including today.	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+ <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused
➤ Total number of months homeless on the street or in an emergency shelter in the past 3 years.	<input type="checkbox"/> 1 (This time is the 1 st month) <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> More than 12 mos <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

➤ Is Client Homeless	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>YES if in Emergency Shelter; Usually YES if in Street Outreach</i>

➤ LC Client Contact Information (please enter in ClientPoint Client Profile) ANSWER FOR HEAD of HOUSEHOLD			
Permanent Mailing Address:			Email:
Residential Address (If different from mailing):			
Contact Number:	<input type="checkbox"/> Cell:	<input type="checkbox"/> Voice:	<input type="checkbox"/> Other:

INTAKE WORKER SIGNATURE CERTIFIES THAT THE INTAKE WORKER HAS VERBALLY INFORMED THE CLIENT THAT THIS DATA WILL BE SHARED WITH PARTICIPATING PROVIDERS IN THE LANE COUNTY HOMELESS AND CLIENT MANAGEMENT INFORMATION SYSTEM (HMIS/CMIS)- SERVICEPOINT – and has DOCUMENTED VERBAL OR WRITTEN CONSENT FROM THE CLIENT		APPLICANT SIGNATURE CERTIFIES THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF YOUR KNOWLEDGE AND THAT YOU UNDERSTAND THAT YOUR INFORMATION MAY BE SHARED WITH PARTICIPATING LANE COUNTY PROVIDERS IN SERVICEPOINT(HMIS/CMIS)	
➤ Intake Worker Printed Name	➤ Intake Worker Signature	➤ Applicant Signature	➤ Date