**INSTRUCTIONS:** Complete this form for the head of household and the “Household Member” intake form separately for each additional household member. Paper forms should be stored in the client’s file at the Access Point per CoC regulations. Instructions for the assessor appear throughout the document in orange.

**ASSESSOR SCRIPT:** *“Today we're doing an assessment to see if you qualify for assistance with housing in Marion County. Some resources are available for people at risk of experiencing homelessness. Others are for those who are sleeping outside, in a shelter, or fleeing domestic violence. If your situation changes and you find other housing, you may not be eligible for our system resources after that.*

*I'm going to ask you a lot of questions and it is important that you answer honestly to determine what you're eligible for. Questions are not meant to prevent you from receiving resources. The needs of the community are greater than our resources. This assessment is to help us understand your housing needs, but it is important that you keep looking for other housing options too. Do you want to continue?”*

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| **BASIC CLIENT INFORMATION: For head of household.** Complete the client's identifying information. Name and social security number have associated data quality fields. Data quality fields are used to indicate the reason full information wasn't collected. Name and social security number data quality fields allow users to indicate when a client doesn't know or refuses to provide information. If the required data is collected then ClientTrack automatically records that full data quality was met. |

Assessment date: **11/30/2021 First Name\*:** Click or tap here to enter text.

**Middle Name:** Click or tap here to enter text. **Last Name\*:** Click or tap here to enter text.

**Suffix:** Click or tap here to enter text. **Name Quality\*:** Choose an item.

**SSN:** XXX-XX-XXXX **SSN Quality\*:** Choose an item.

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| **BASIC CLIENT DEMOGRAPHICS: For head of household only** |

**Birth Date:** Click or tap to enter a date. **Client Age:** Click or tap here to enter text.

**Date of birth quality\*:** Choose an item. **Ethnicity\*:** Choose an item.

**Race (choose all that apply)\*:**

American Indian, Alaska Native, or Indigenous

Asian or Asian American

Black, African American, or African

Native Hawaiian or Pacific Islander

White

Client doesn’t know

Client refused

Data not collected

**Gender (choose all that apply)\*:**

Female

Male

A gender other than singularly female or male (e.g., non-binary, genderfluid, agender, culturally specific gender)

Transgender

Questioning

Client doesn’t know

Client refused

Data not collected

**Pronouns (if given):** Choose an item. **Sexual Orientation:** Choose an item.

**Veteran Status\*:** Choose an item. **Marital Status:** Choose an item.

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| **CONTACT INFORMATION:** |

**Address:** Click or tap here to enter text.

**City, State, Zip Code:** City**,** StateZip Code

**Email:** Click or tap here to enter text. **Primary Phone:** (XXX) XXX-XXXX

**Work Phone:** (XXX) XXX-XXXX **Msg Phone:** (XXX) XXX-XXXX

If you are completing a paper assessment because the client has not consented to have their information in HMIS, do not complete the CES ROI. Instead, complete and file this paper form then submit the [Confidential Application (Inclusion Form)](https://www.indycoc.org/s/CES-Confidential-Inclusion-Form.pdf) to [CES@chipindy.org](mailto:CES@chipindy.org) for an anonymous CES enrollment. Instructions can be found [here](https://www.indycoc.org/s/CES-Confidential-Application-Instructions.pdf).

Otherwise, please complete the following CES ROI and upload signed copy to Document Check and receive verbal consent to sign electronic ROI in the enrollment workflow.

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| **CLIENT RELEASE OF INFORMATION & SHARING PLAN (see next page)** |

**Introduction**: This application will be used to help identify your needs and refer you to housing programs. Please understand that the information you provide will be input into the Homeless Management Information System (HMIS), which many homeless service providers in Indianapolis use to keep information about people that they help. Although we will share some of your information for the purposes of helping you connect to resources, we have strict rules about sharing and everyone using HMIS is trained to protect your information. If you do not want to share your information in HMIS, we can complete a confidential application and can still help you connect to resources.

**SECTION 1 - Identifying Information in HMIS**

**This basic identifying information is collected about you and your family members and can be seen by all Indianapolis agencies that use HMIS:**

* Name
* Gender
* Social security number
* Date of birth
* Race, ethnicity
* Marital status
* Veteran status
* Phone number, address

**Why do we collect information about you?**

* Work with other agencies to help you
* Help case managers work together for you
* Connect you with other helping agencies or benefits you may be eligible for
* Reduce the number of times you have to tell your story
* Identify where there are gaps in our community resources so we can work to fill them

**SECTION 2 – Coordination of Care Sharing Plan for CES**

Many Indianapolis agencies also use the Coordinated Entry System (CES) to improve services to you through coordination of care. If you receive services from multiple agencies that participate in CES, agreeing to the Sharing Plan defined below allows for these agencies to see your information.

**The information shared about you and your family members through the Coordination of Care Sharing Plan includes the basic identifying information listed in Section 1 and:**

* Homeless status and history
* Type of housing you are eligible for
* Domestic violence history
* Insurance information
* Income information
* Medical information including presence of mental or physical health conditions, disability, substance abuse, pregnancy status

**I understand that:**

I can receive a copy of the Privacy Notice/script that explains HMIS and my rights and responsibilities associated with how information is kept and shared through this system, upon request.

I understand that the confidentiality of my records is protected by law. I understand that this agency will never give information about me to anyone outside the agency without my specific written consent through a Sharing Plan or as required by law (The regulations are the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CRF, Parts 160 & 164) and certain Indiana State laws.

I understand that the information I provide will be used to determine if I am eligible for partner agency housing, services, or related programs. I also understand that each agency may have different eligibility requirements.

I understand that if I have a domestic violence history, details regarding specific incidents will NOT be shared nor will other housing agencies have access to this information unless I have given my consent.

I understand that I am signing this consent as a release of information so that my information may be shared with housing providers at housing case conferencing for housing referral and placement purposes. Only relevant information that would impact eligibility will be discussed.

I can withdraw my consent to share at any time; however, any information already shared with another agency cannot be taken back. I also understand that the request to discontinue sharing will have to be coordinated between sharing partners. If I withdraw my consent, I should tell any agencies that I see who are included on the Plan.

I understand that the refusal to share information in this system will not be used to deny me services such as emergency assistance, outreach, shelter, or housing assistance.

I can get a list of the partner agencies that will be able to see my information upon request.

I understand that a copy of this authorization is as valid as the original.

**SECTION 3 – Signatures**

**Instructions:** By signing below you understand and agree to all your information being visible to all participating partner agencies according to the Sharing Plan.

***This release is active until revoked.***

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed: **11/30/2021**

Signature of guardian or authorized representative (when required): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date signed by guardian/authorized representative: **11/30/2021**

Assessor signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **HUD PROGRAM ENROLLMENT:** Indy Coordinated Entry |

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| **UNIVERSAL DATA ASSESSMENT: For head of household only** |

**Assessment Date\*:** Click or tap to enter a date. **Assessor Name\*:** Click or tap here to enter text.

**Disabling Condition\*:** Choose an item.

**CLIENT LOCATION:** IN-503 – Indianapolis CoC

**PRIOR LIVING SITUATION:** Identify the type of residence and length of stay at that residence just prior to (i.e., the night before) program admission.

**Prior living situation\*:** Choose an item.

* ***If in an institutional situation, also answer:* Did you stay less than 90 days?** Choose an item.
* ***If in a transitional or permanent housing situation, also answer:* Did you stay less than 7 nights?** Choose an item.

**Length of stay in the prior living situation\*:** Choose an item.

**On the night before did you stay on the streets, ES, or SH\*?** Choose an item.

***Assessor: if household meets HUD’s definition of homelessness under Category 1 or 4, complete the following questions. If not, skip them and continue to Health Insurance section.***

* + **Approximate date homelessness started:** Click or tap to enter a date.
  + **Regardless of where they stayed last night, what is the number of times the client has been on the streets, in ES, or SH in the past three years including today:** Choose an item.
  + **Total number of months homeless, on the streets, in ES, or SH in the past three years:** Choose an item.

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**HEALTH INSURANCE (choose all that apply):**

Private

Private- Individual

Private – Employer

Health insurance obtained through COBRA

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 Service (HIS)

Other

No Insurance

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| **CRISIS NEEDS ASSESSMENT/TRIAGE ASSESSMENT** |

***Assessor: If current living situation is an institution or transitional or permanent housing, ask the following – otherwise, skip to question 2:***

1. **Is client going to have to leave their current living situation within 14 days?** Choose an item.

***Assessor: if yes, answer the following. If no, skip to question 2:***

* 1. **Has a subsequent residence been identified?** Choose an item.
  2. **Does individual or family have resources or support networks to obtain other permanent housing?** Choose an item.
  3. **Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?** Choose an item.
  4. **Has the client moved 2 or more times in the last 60 days?** Choose an item.

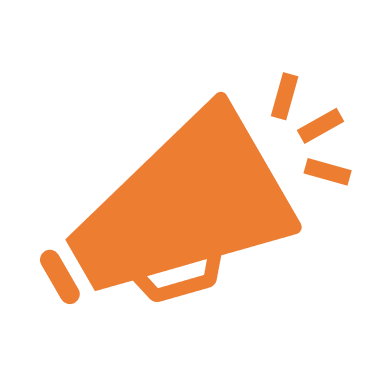
1. **Is the client a survivor of domestic violence? This includes domestic violence, sexual assault, trading sex for housing (survival sex), trafficking (forced or coerced into sexual or labor activities), violence or threats of violence because of sexual orientation or gender identity:** Choose an item.

***Assessor: if yes, answer the following; otherwise, skip to the next question:***

* 1. **When did the domestic violence experience occur?** Choose an item.
  2. **Is the client currently fleeing domestic violence, or attempting to do so? This includes situations where they are homeless due to actively fleeing or attempting to flee intimate partner violence, sexual assault, stalking or other dangerous or life threatening conditions related to violence against them or their family:**Choose an item.

***Assessor: if client is age 16-24, please complete the following. Otherwise, skip to the orange box.***

1. **Are you interested in being referred to a host home project?** Choose an item.
2. **Are you currently in foster care or connected to the Department of Child Services, or were you in the past?** Choose an item.

****

**Assessor: You have completed the crisis needs assessment. Continue with the remainder of the assessment if the client is:**

* **Literally homeless (currently staying in a place not meant for habitation, an emergency shelter, the Anthem Save Haven, a hotel or motel paid for by a non-profit agency or the government)**
* **Fleeing or attempting to flee DV**
* **Currently in or about to enter transitional housing or a YHDP Host Home**

**OTHERWISE, STOP THE ASSESSMENT HERE and refer the client to community resources as needed.**

**Complete the following section if client identifies as a veteran. Otherwise, skip to Barriers Assessment**

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| **VETERAN ASSESSMENT** |

**Branch and Discharge status:** Please select the branch and discharge status. The HMIS Data Manual provides the following instructions for veterans serving in more than one branch: “For veterans who served in more than one branch of the military, select the branch in which the veteran spent the most time. In the event that a client’s discharge status is upgraded during enrollment, the record should be edited to reflect the change.”

**Branch of the military\*:** Choose an item. **Discharge status\*:** Choose an item.

**Military Service Dates:** In the interest of data quality ClientTrack provides date fields and encourages users to enter exact dates if possible. If not, use the first of the year or another standard date determined by your organization. For HMIS purposes, ClientTrack will always calculate years of military service only using year.

**Service entry date\*:** Click or tap to enter a date. **Service exit date:** Click or tap to enter a date.

**Please select theatre(s) of operations(s):**

Theatre of Operations: World War II Choose an item.

Theatre of Operations: Vietnam War Choose an item.

Theatre of Operations: Persian Gulf War (Operation Desert Storm) Choose an item.

Theatre of Operations: Afghanistan (Operation Enduring Freedom) Choose an item.

Theatre of Operations: Iraq (Operation Iraqi Freedom) Choose an item.

Theatre of Operations: Iraq (Operation New Dawn) Choose an item.

Theatre of Operations: Other Peace-Keeping Operations or Military Interventions (such as Lebanon, Panama, Somalia, Bosnia, Kosovo) Choose an item.

Theatre of Operations: Korean War Choose an item.

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| **BARRIERS/SPECIAL NEEDS** | | |
| **ALCOHOL ABUSE** | | |
| Barrier present? Choose an item. | | |
| ***If yes:*** | Condition is indefinite? Choose an item. | Explanation:  Click or tap here to enter text. |
| **CHRONIC HEALTH CONDITION** (defined as a diagnosed condition that is more than 3 months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance) | | |
| Barrier present? Choose an item. | | |
| ***If yes:*** | Condition is indefinite? Choose an item. | Explanation:  Click or tap here to enter text. |
| **DEVELOPMENTAL DISABILITY** | | |
| Barrier present? Choose an item. | | |
| ***If yes:*** | Condition is indefinite? Choose an item. | Explanation:  Click or tap here to enter text. |
| **DRUG ABUSE** | | |
| Barrier present? Choose an item. | | |
| ***If yes:*** | Condition is indefinite? Choose an item. | Explanation:  Click or tap here to enter text. |
| **HIV/AIDS** | | |
| Barrier present? Choose an item. | | |
| ***If yes:*** | Condition is indefinite? Choose an item. | Explanation:  Click or tap here to enter text. |
| **MENTAL HEALTH** | | |
| Barrier present? Choose an item. | | |
| ***If yes:*** | Condition is indefinite? Choose an item. | Explanation:  Click or tap here to enter text. |
| **OTHER** | | |
| Barrier present? Choose an item. | | |
| ***If yes:*** | Condition is indefinite? Choose an item. | Explanation:  Click or tap here to enter text. |
| **PHYSICAL DISABILITY** | | |
| Barrier present? Choose an item. | | |
| ***If yes:*** | Condition is indefinite? Choose an item. | Explanation:  Click or tap here to enter text. |
| **FELONY CONVICTION** | | |
| Barrier present? Choose an item. | | |
| ***If yes:*** | Condition is indefinite? Choose an item. | Explanation:  Click or tap here to enter text. |
| **HISTORY OF FOSTER CARE** | | |
| Barrier present? Choose an item. | | |
| ***If yes:*** | Condition is indefinite? Choose an item. | Explanation:  Click or tap here to enter text. |
|  |  |  |
| **INCOME. Indicate below the client’s sources of MONTHLY income, non-cash benefits, and expenses. The following instructions are quoted from the HMIS Data Manual:**   * When a client has income, but does not know the exact amount, a “Yes” response should be recorded for both the overall income question and the specific source, and the income amount should be estimated. * Income received by or on behalf of a minor child should be recorded as part of household income under the Head of Household, unless the federal funder in the HMIS Program Specific Manual instructs otherwise. Income should be recorded at the client-level for heads of household and adult household members. Projects may choose to collect this information for all household members including minor children, as long as this does not interfere with accurate reporting per funder requirements. Projects collecting data through client interviews should ask clients whether they receive income from each of the sources listed rather than asking them to state the sources of income they receive. * Income data should be recorded only for sources of income that are current as of the information date (i.e. have not been specifically terminated). As an example, if a client’s employment has been terminated and the client has not yet secured additional employment, the response for Earned income would be “No.” As a further example, if a client’s most recent paycheck was 2 weeks ago from a job in which the client was working full time for $15.00/hour, but the client is currently working 20 hours per week for $12.00 an hour, record the income from the job the client has at the time data are collected (i.e. 20 hours at $12.00 an hour). | | |

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| **ALIMONY** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **CHILD SUPPORT** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **EMPLOYMENT** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **OTHER INCOME** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **PRIVATE DISABILITY INSURANCE** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **SOCIAL SECURITY** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **SOCIAL SECURITY DISABILITY** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **SUPPLEMENTAL SECURITY INCOME** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **TANF** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **UNEMPLOYMENT BENEFITS** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **VETERAN BENEFITS** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **VETERAN’S DISABILITY** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **VETERAN’S PENSION** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **WORKER COMPENSATION BENEFITS** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **PENSION OR RETIREMENT INCOME FOR A FORMER JOB** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |

**NON-CASH BENEFITS: Choose all that apply**

|  |  |  |
| --- | --- | --- |
| **FOOD STAMPS** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **HEALTHY INDIANA PLAN** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **HOOSIER HEALTHWISE** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **MEDICAID** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **MEDICARE** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **OTHER NON-CASH BENEFITS** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **PRIVATE HEALTH INSURANCE** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **SECTION 8, PUBLIC HOUSING, OR OTHER RENTAL ASSISTANCE** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **STATE CHILDREN’S HEALTH INSURANCE PROGRAM** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **TEMPORARY RENTAL ASSISTANCE** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **VETERAN’S HEALTH CARE** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **WISHARD ADVANTAGE** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **TANF CHILD CARE SERVICES** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **TANF TRANSPORTATION SERVICES** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |
| **OTHER TANF-FUNDED SERVICES** | | |
| ***If yes:*** | Description:  Click or tap here to enter text. | Monthly amount:  Click or tap here to enter text. |

**--------------------------------Assessor: Complete VI-SPDAT on separate form--------------------------------**

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| **COORDINATED ENTRY ASSESSMENT** |

**INTERVENTIONS:** Please check all interventions that the client is eligible for.

Sort-term housing assistance (Rapid

Rehousing)

Permanent Supportive Housing (PSH)

HVAF ESG RRH

Veteran Transitional Housing (GPD)

Veteran Rapid Re-Housing (SSVF)

Veteran Permanent Supportive Housing

(HUD-VASH)

VOA Contract

**ELIGIBILITY**

**What is the minimum number of bedrooms required\*?** Choose an item.

**Do you have any ADA or accessibility needs\*?** Choose an item.

* ***If yes*, please provide details:** Click or tap here to enter text.

**Do you need a pet friendly unit\*?** Choose an item.

**Are you or anyone in your household currently required to be on the sex offender registry? \*** Choose an item.

* ***If yes*, offender registry duration\*:** Choose an item.

**If you are currently fleeing/attempting to flee DV OR your homelessness was caused by DV, approximate date homelessness began:** Click or tap to enter a date.

**DV Lethality Score:** Choose an item. **Connected to DV Provider:** Choose an item.

**Have you or anyone in your household ever been convicted of arson\*?** Choose an item.

**Have you or anyone in your household ever been convicted of drug-related activity for the production or manufacture of methamphetamine on the premises of federally assisted housing\*?** Choose an item.

**Additional comments (include information about active court cases or warrants here):** Click or tap here to enter text.

**------------------------------End of CES Head of Household Enrollment-----------------------------**

**Don’t forget to complete a “Household Member” form for each additional family member!**