

**DuPage CoC Initial Intake Assessment**

Head of Household / All Adult HH Members

HMIS Client ID#

Project Name



Fill in after HMIS Project Entry

**Entry Date (Project Start)**

**Date of Engagement (ES/SO)**

**Housing Move-in Date (PH, PSH, RRH)**




Month / Day / Year

Month / Day / Year

Month / Day / Year

**HEAD OF HOUSEHOLD** (A client's full and accurate name should be used, but the recording of a legal name is not required, unless specified by a funder.)

<b>Client doesn't know</b>	<b>Client prefers not to answer</b>
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First Name		Middle Name		<input type="checkbox"/>		<input type="checkbox"/>
Last Name		Suffix (e.g. Jr, Sr, III)		<input type="checkbox"/>		<input type="checkbox"/>
		Alias				
SSN			Approx. or Partial SSN Reported <input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Veteran Status	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Veteran Status is on the Client Profile Tab and may need to be updated if the client is already in the HMIS.</i>			<input type="checkbox"/>		<input type="checkbox"/>
Relationship (to HoH)	<input type="checkbox"/> <b>SELF (Head of Household)</b> <input type="checkbox"/> HoH's Child <input type="checkbox"/> HoH's Other Relation <input type="checkbox"/> HoH's Spouse/Partner <input type="checkbox"/> Other: Non-Relation		<b>Use a separate Initial Intake Assessment or HH Member Supplemental page for each additional HH member.</b>			
Date of Birth			Approx. or Partial DOB Reported <input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Gender	A client's gender may not match the sex they were assigned at birth.	<input type="checkbox"/> Woman (Girl, if child) <input type="checkbox"/> Man (Boy, if child) <input type="checkbox"/> Transgender <input type="checkbox"/> Non-Binary <input type="checkbox"/> Culturally Specific Identity (e.g. Two Spirit) <input type="checkbox"/> Questioning <input type="checkbox"/> Different Identity, specify:		<input type="checkbox"/>		<input type="checkbox"/>
How does the client identify their sexual orientation?	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Other, specify:			<input type="checkbox"/>		<input type="checkbox"/>
Race and Ethnicity	<input type="checkbox"/> American Indian, Alaska Native or Indigenous <input type="checkbox"/> Hispanic/Latina/e/o <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> White		<input type="checkbox"/> Black, African American or African <input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/>		<input type="checkbox"/>
<b>Additional Race and Ethnicity Detail</b> The question allows the client to share additional specificity about how they identify or express their ethnicity, race, or nationality, using terms that may not be addressed by the standard responses above (e.g. Potawatomi Tribe, Hmong, Haitian, Arab-American).						
Translation Assistance Needed	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/>		<input type="checkbox"/>
Preferred Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Polish <input type="checkbox"/> Other preferred language, specify:			<input type="checkbox"/>		<input type="checkbox"/>

<b>VICTIM OF DOMESTIC VIOLENCE (DV)</b>  <i>DV includes "domestic violence, dating violence, sexual assault, stalking, or other dangerous, traumatic, or life-threatening conditions related to the violence against the individual's or family's current housing situation." (HEARTH Act)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
	(If Yes) how long ago was the last incident? <input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 3-6 months ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> More than a year ago <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer  (If Yes) are you currently fleeing? (This includes currently attempting to flee.) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client does not know <input type="checkbox"/> Client prefers not to answer
<b>General Health Status</b> (RHY and VASH projects only)	<input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

<b>DISABILITY ASSESSMENT</b>						
Does the client have a disabling condition expected to be of long duration and impedes ability to live independently?						
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer						
Disability Type	(If Yes) Start Date	Will the Condition be long term?	Disability Determination		If Yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	
<b>Alcohol Use Disorder</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	____ / ____ / ____ Notes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<b>Chronic Health Condition</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	____ / ____ / ____ Notes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<b>Developmental Disability</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	____ / ____ / ____ Notes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<b>Drug Use Disorder</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	____ / ____ / ____ Notes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<b>HIV/AIDS</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	____ / ____ / ____ Notes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<b>Mental Health Disorder</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	____ / ____ / ____ Notes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<b>Physical Disability</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	____ / ____ / ____ Notes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

# Chronic Homelessness (CH) Assessment

**PRIOR LIVING SITUATION:** *Where was the client sleeping last night? Or, in other words, what was the client's living situation just prior to entering this project? For non-residential programs (like HP), this is their current situation.*

**Choose from Literally Homeless Situation OR Institutional Setting OR Temporary/PH Situation. Once chosen, stay in that column.**

<p><b>1A. Homeless Situation</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)</li> <li><input type="checkbox"/> Emergency Shelter (including hotel or motel paid for with emergency shelter voucher, or Host Home shelter)</li> <li><input type="checkbox"/> Safe Haven</li> <li><input type="checkbox"/> Client doesn't know</li> <li><input type="checkbox"/> Client prefers not to answer</li> </ul> <p style="text-align: center;">↓ <i>Next Answer 2A: Length of Stay.</i> ↓</p>	<p><b>1B. Institutional Situation</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Foster care home or foster care group home</li> <li><input type="checkbox"/> Hospital or other residential non-psychiatric medical facility</li> <li><input type="checkbox"/> Jail, prison, or juvenile detention facility</li> <li><input type="checkbox"/> Long-term care facility or nursing home</li> <li><input type="checkbox"/> Psychiatric hospital or other psychiatric facility</li> <li><input type="checkbox"/> Substance abuse treatment facility or detox center</li> <li><input type="checkbox"/> Client doesn't know</li> <li><input type="checkbox"/> Client prefers not to answer</li> </ul> <p style="text-align: center;">↓ <i>Next Answer 2B: Length of Stay.</i> ↓</p>	<p><b>1C. Temporary Situation</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Transitional Housing for homeless persons (including homeless youth)</li> <li><input type="checkbox"/> Residential/halfway house, NO homeless criteria</li> <li><input type="checkbox"/> Hotel or motel paid for without ES voucher</li> <li><input type="checkbox"/> Host Home (non-crisis)</li> <li><input type="checkbox"/> Staying or living in a friend's room, apt, or house</li> <li><input type="checkbox"/> Staying or living in a family member's room, apt, or house</li> <li><input type="checkbox"/> Client doesn't know</li> <li><input type="checkbox"/> Client prefers not to answer</li> </ul> <p style="text-align: center;">-OR-</p> <p><b>1C. Permanent Housing Situation</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Rental by client, NO ongoing housing subsidy</li> <li><input type="checkbox"/> Rental by client, with ongoing subsidy</li> </ul> <p><b>IDENTIFY SUBSIDY TYPE:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> GPD TIP housing subsidy</li> <li><input type="checkbox"/> VASH housing subsidy</li> <li><input type="checkbox"/> RRH or equivalent subsidy</li> <li><input type="checkbox"/> HCV voucher (tenant or project based) (not dedicated)</li> <li><input type="checkbox"/> Public housing unit</li> <li><input type="checkbox"/> Rental by client, with other ongoing housing subsidy</li> <li><input type="checkbox"/> Housing Stability Voucher</li> <li><input type="checkbox"/> Family Unification Program Voucher (FUP)</li> <li><input type="checkbox"/> Foster Youth to Independence Initiative (FYI)</li> <li><input type="checkbox"/> Permanent Supportive Housing</li> <li><input type="checkbox"/> Other permanent housing dedicated for formerly homeless persons</li> </ul> <ul style="list-style-type: none"> <li><input type="checkbox"/> Owned by client, with ongoing housing subsidy</li> <li><input type="checkbox"/> Owned by client, NO ongoing housing subsidy</li> <li><input type="checkbox"/> Client doesn't know</li> <li><input type="checkbox"/> Client prefers not to answer</li> </ul> <p style="text-align: center;">↓ <i>Next Answer 2C: Length of Stay.</i> ↓</p>
<p><b>2A: LENGTH OF STAY:</b> <i>How long was the client in a Homeless Situation?</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> One night or less</li> <li><input type="checkbox"/> Two to six nights</li> <li><input type="checkbox"/> One week or more, but less than one month</li> <li><input type="checkbox"/> One month or more, but less than 90 days</li> <li><input type="checkbox"/> 90 days or more, but less than one year</li> <li><input type="checkbox"/> One year or longer</li> <li><input type="checkbox"/> Client doesn't know</li> <li><input type="checkbox"/> Client prefers not to answer</li> </ul> <p style="text-align: center;">↓ <i>Next Answer 3: Chronic Questions</i> ↓</p>	<p><b>2B: LENGTH OF STAY:</b> <i>How long was the client in an Institutional Situation?</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> One night or less<sup>p</sup></li> <li><input type="checkbox"/> Two to six nights<sup>p</sup></li> <li><input type="checkbox"/> One week or more, but less than one month<sup>p</sup></li> <li><input type="checkbox"/> One month or more, but less than 90 days<sup>p</sup></li> <li><input type="checkbox"/> 90 days or more, but less than one year</li> <li><input type="checkbox"/> One year or longer</li> <li><input type="checkbox"/> Client doesn't know</li> <li><input type="checkbox"/> Client prefers not to answer</li> </ul> <p style="text-align: right;">} 90 days or less</p> <p><sup>p</sup><i>If the client reported 90 days or less, then answer the question below. If the client reports more than 90 days, the client is NOT considered to be experiencing CH at this point in time, skip the rest of this page.</i></p> <p><b>On the night before the Institutional Situation, did the client stay on the streets, in ES or SH?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes (proceed below to 3: Chronic Questions)</li> <li><input type="checkbox"/> No (the client is NOT considered to be experiencing CH at this point in time, skip the rest of this page)</li> </ul>	<p><b>2C: LENGTH OF STAY:</b> <i>How long was the client in a Housing Situation?</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> One night or less<sup>p</sup></li> <li><input type="checkbox"/> Two to six nights<sup>p</sup></li> <li><input type="checkbox"/> One week or more, but less than one month</li> <li><input type="checkbox"/> One month or more, but less than 90 days</li> <li><input type="checkbox"/> 90 days or more, but less than one year</li> <li><input type="checkbox"/> One Year or Longer</li> <li><input type="checkbox"/> Client doesn't know</li> <li><input type="checkbox"/> Client prefers not to answer</li> </ul> <p style="text-align: right;">} 6 nights or less</p> <p><i>If Client is entering ES, SH, or SO, then answer the question below OR...</i></p> <p><sup>p</sup><i>If the client reported 6 nights or less, then answer the question below.</i></p> <p><i>If the client reports 7 days or more AND is NOT entering ES, SH, or SO, then the client is NOT considered to be experiencing CH at this point in time, skip the rest of this page.</i></p> <p><b>On the night before the TH/PH Housing Situation, did the client stay on the streets, in ES or SH?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes (proceed below to 3: Chronic Questions)</li> <li><input type="checkbox"/> No (the client is NOT considered to be experiencing CH at this point in time, skip the rest of this page)</li> </ul>

<b>3: CHRONIC HOMELESSNESS (CH) QUESTIONS:</b> <i>(depending on your answer in the above questions).</i>	
3.1: When did the client first become homeless? <i>Have the client look back to when they first became homeless (not this episode, but the very first time) and enter that approximate date.</i>	M/D/Y
3.2: Approximate Date <u>this current episode</u> of homelessness began? <i>Have the client look back to the date of the last time the client had a place to sleep for more than 7 days that was not on the streets, in ES, or SH.</i>	M/D/Y
3.3: Regardless of where they stayed last night -- Number of times (episodes) the client has been homeless on the streets, in ES, or SH in the past three years including today. <i>If this is the first time the client has been homeless in the past 3 years then the response is One Time.</i> <ul style="list-style-type: none"> <li>• <i>A NEW EPISODE SHOULD BE COUNTED AFTER EACH TIME THE CLIENT HAD HOUSING FOR 7 DAYS OR LONGER (AT A FRIEND'S OR FAMILY MEMBER'S OR OTHER NON-HOMELESS SITUATION) OR WAS IN AN INSTITUTIONAL SETTING FOR 90 DAYS OR MORE.</i></li> </ul>	<input type="checkbox"/> One Time <input type="checkbox"/> Two Times <input type="checkbox"/> Three Times <input type="checkbox"/> Four or more times <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
3.4: Total number of months on the street, in ES or SH in the past 3 years: <i>the number of cumulative but not necessarily consecutive months spent homeless.</i>	Number of Months

**ENROLLMENT COC**

Client Location should always be IL-514 DuPage except for SSVF when a client is in a non-DuPage project

- |   |   |
|---|---|
| <input type="checkbox"/> IL-502 Waukegan/North Chicago/Lake Cty   | <input type="checkbox"/> IL-512 Bloomington/Central Illinois/Kankakee |
| <input type="checkbox"/> IL-506 Joliet/Kendall/Grundy/Will County | <input checked="" type="checkbox"/> <b>IL-514 DuPage</b>              |
| <input type="checkbox"/> IL-509 De Kalb                           | <input type="checkbox"/> IL-517 Aurora/Elgin/Kane                     |
| <input type="checkbox"/> IL-511 SubCook                           | <input type="checkbox"/> IL-518 Northwest/LaSalle                     |

Enter City the client most closely associates with—this might be the city of their last permanent address, or it might be the city where the client currently spends the most time.

CLIENT ZIP: \_\_\_\_\_

CLIENT CITY: \_\_\_\_\_

**CLIENT'S RESIDENCE**

Client's Street Address				Apt #	
City, Township		State		Zip	
Address Data Quality	<input type="checkbox"/> Full Address Reported <input type="checkbox"/> Client Does Not Know		<input type="checkbox"/> Incomplete or estimated address reported <input type="checkbox"/> Client Refused		
Home Phone #		Cell Phone #		Alternate Contact	
Email Address					
Start Date		End Date			
Address Type	<input type="checkbox"/> After Program <input type="checkbox"/> Before Program-Last Permanent		<input type="checkbox"/> Before Program <input type="checkbox"/> Program (while in your project)		
Client's Residence Notes					

**EMERGENCY CONTACT (OPTIONAL)**

Contact's Name					
Contact's Address				Apt #	
Contact's City		Contact's State		ZIP	
Phone #		Second Phone #			
Relationship to Client					
Start Date		End Date			
Is there a release of information to contact this person?	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Continue to Household Income

**HOUSEHOLD INCOME**

Does the household have any current income?

- Yes     No     Client doesn't know     Client prefers not to answer

If **No**, answer the following question and move on to Household Income for AMI Below:

If **Yes**: Please indicate in each source if the household receives the income, and if they do, the household member receiving the income, the monthly amount (to the nearest dollar) of each source, and the income start date.

			HH Member	Amount	Start Date	HH Member	Amount	Start Date
<b>Earned Income</b>								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	
				\$			\$	
<b>Unemployment Insurance</b>								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	
<b>SSI: Supplemental Security Income</b>								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	
<b>SSDI: Social Security Disability Income</b>								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	
<b>VA Service Connected Disability Compensation</b>								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	
<b>Private Disability Insurance</b>								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	
<b>Worker's Compensation</b>								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	
<b>TANF: Temporary Assistance for Needy Families</b>								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	
<b>General Assistance</b>								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	
<b>Retirement Income from Social Security</b>								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	
<b>VA Non-Service Connected Disability Pension</b>								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	
<b>Pension or retirement income from another job</b>								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	
<b>Child Support</b>								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	
<b>Alimony or Other Spousal Support</b>								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	
<b>Other Source (specify):</b>								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	

For Each **Individual** Household Member with income, record their individual total income from all sources below

Household Member	Total Monthly Income	Household Member	Total Monthly Income

**TOTAL MONTHLY HOUSEHOLD INCOME**    \$ \_\_\_\_\_

**NUMBER OF HOUSEHOLD MEMBERS**    \_\_\_\_\_

**FY2023 AREA MEDIAN INCOME (AMI)**

Household Size	1	2	3	4	5	6	7	8
15% AMI	\$967	\$1,104	\$1,242	\$1,379	\$1,490	\$1,600	\$1,711	\$1,821
30% AMI	\$1,933	\$2,208	\$2,483	\$2,758	\$2,979	\$3,200	\$3,421	\$3,642
50% AMI	\$3,221	\$3,679	\$4,138	\$4,596	\$4,967	\$5,333	\$5,700	\$6,067
80% AMI	\$5,150	\$5,883	\$6,621	\$7,354	\$7,946	\$8,533	\$9,121	\$9,708
100% AMI	\$6,442	\$7,358	\$8,275	\$9,358	\$9,933	\$10,667	\$11,400	\$12,133

**TOTAL MONTHLY HOUSEHOLD INCOME AS PERCENTAGE OF AMI:**

30% OR LESS
  31%-50%
  51%-80%
  81% OR GREATER

**NON-CASH BENEFITS**

Does the household currently receive any Non-Cash Benefits?

Yes
  No
  Client doesn't know
  Client prefers not to answer

Please indicate which of the following non-cash benefits you have received over the last 30 days.

*(You may use "All" if all household members receive the benefit)*

	Start Date	Amount (optional)
Supplemental Nutrition Assistance Program (Food Stamps)		
<input type="checkbox"/> Yes <input type="checkbox"/> No                       If Yes, Household Members:		
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)		
<input type="checkbox"/> Yes <input type="checkbox"/> No                       If Yes, Household Members:		
TANF childcare services		
<input type="checkbox"/> Yes <input type="checkbox"/> No                       If Yes, Household Members:		
TANF transportation services		
<input type="checkbox"/> Yes <input type="checkbox"/> No                       If Yes, Household Members:		
Other TANF-Funded Services		
<input type="checkbox"/> Yes <input type="checkbox"/> No                       If Yes, Household Members:		
Other Source (specify):		
<input type="checkbox"/> Yes <input type="checkbox"/> No                       If Yes, Household Members:		

**COVERED BY HEALTH INSURANCE**

Do household members currently have health insurance?

Yes
  No
  Client doesn't know
  Client prefers not to answer

*Continue to the Health Insurance Sub-Assessment*

**Complete the following** (You may use "All" if all household members receive the benefit)

*Start Date*

<b>Medicaid</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:	
<b>Medicare</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:	
<b>Illinois All Kids (State Children's Health Insurance Program)</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:	
<b>Veteran's Health Administration (VHA)</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:	
<b>Employer Provided Health Insurance</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:	
<b>Health Insurance obtained through COBRA</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:	
<b>Private Pay Health Insurance</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:	
<b>State Health Insurance for Adults</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:	
<b>Indian Health Services Program</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:	
<b>Other</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:	
If "Yes" to Other, Specify Source:		

*end of health insurance questions*



**All Applicants Must Sign Below**

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*By signing below, I attest that the information I have provided for eligibility and intake is a true and accurate account of the current situation, income and household.*

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agency Representative signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agency Representative Name (print): \_\_\_\_\_

**DuPage HP and IDHS ETH  
Supplemental Assessments**

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**HOMELESSNESS PREVENTION SUPPLEMENTAL (ALL HP PROJECTS)**

Food Stamp status at time of intake:       Currently Enrolled     Enrolled at Intake     Ineligible

LIHEAP status at time of intake:       Currently Enrolled     Enrolled at Intake     Ineligible

Reason client is seeking assistance:       Maintain current housing  
 Move from current residence to other permanent housing  
 Move from shelter to permanent housing

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**IDHS ETH/EF&S SUPPLEMENTAL (IDHS ETH ONLY)**

Number of other shelters used in prior year:     None     1     2     3     4     5 or more

Food Stamp status at time of intake:       Currently Enrolled     Enrolled at Intake     Ineligible

Emancipated minor or unaccompanied youth?     Yes     No

Ex-offender?       Yes     No

Have you ever been convicted of a felony?     Yes     No

Pregnant Now?       Yes     No     Client Does Not Know     Client Refused

Is juvenile a parent (under age 18)?       Yes     No

## Initial Intake Assessment HH Member Supplemental

Head of Household Name: \_\_\_\_\_

**HMIS CLIENT ID#**

*Fill in after HMIS Project Entry*

**Entry Date (Project Start)**

*Month / Day / Year*

**NAME OF HOUSEHOLD MEMBER** (A client's full and accurate name should be used, but the recording of a legal name is not required, unless specified by a funder.)

				Client doesn't know	Client prefers not to answer
First Name		Middle Name		<input type="checkbox"/>	<input type="checkbox"/>
Last Name		Suffix (e.g. Jr, Sr, III)		<input type="checkbox"/>	<input type="checkbox"/>
		Alias			
SSN			Approx. or Partial SSN Reported <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Veteran Status	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Veteran Status is on the Client Profile Tab and may need to be updated if the client is already in the HMIS.</i>		<input type="checkbox"/>	<input type="checkbox"/>
Relationship (to HoH)	<input type="checkbox"/> HoH's Child <input type="checkbox"/> HoH's Other Relation <input type="checkbox"/> HoH's Spouse/Partner <input type="checkbox"/> Other: Non-Relation			NA	NA
Date of Birth			Approx. or Partial DOB Reported <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gender	<i>The client may share more than one response and all should be recorded. Except, if the client "doesn't know" or "prefers not to answer," only record this response.</i>	<i>A client's gender may not match the sex they were assigned at birth.</i>	<input type="checkbox"/> Woman (Girl, if child) <input type="checkbox"/> Man (Boy, if child) <input type="checkbox"/> Transgender <input type="checkbox"/> Non-Binary <input type="checkbox"/> Culturally Specific Identity (e.g. Two Spirit) <input type="checkbox"/> Questioning <input type="checkbox"/> Different Identity, specify:	<input type="checkbox"/>	<input type="checkbox"/>
How does the client identify their sexual orientation?	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Other, specify:			<input type="checkbox"/>	<input type="checkbox"/>
Race and Ethnicity	<input type="checkbox"/> American Indian, Alaska Native or Indigenous <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black, African American or African <input type="checkbox"/> Hispanic/Latina/e/o <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White			<input type="checkbox"/>	<input type="checkbox"/>
Additional Race and Ethnicity Detail					
<i>If provided, record additional specificity about how the client identifies or expresses their ethnicity, race, or nationality, using terms that may not be addressed by the standard responses above (e.g. Potawatami Tribe, Hmong, Haitian, Arab-American).</i>					

<b>VICTIM OF DOMESTIC VIOLENCE (DV)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
<i>DV includes "domestic violence, dating violence, sexual assault, stalking, or other dangerous, traumatic, or life-threatening conditions related to the violence against the individual's or family's current housing situation." (HEARTH Act)</i>	(If Yes) how long ago was the last incident? <input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 3-6 months ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> More than a year ago <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer  (If Yes) are you currently fleeing? (This includes currently attempting to flee.) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer		

*Continue to Disability Assessment*

Client Name: \_\_\_\_\_

**DISABILITY ASSESSMENT**

**Does the client have a disabling condition expected to be of long duration and impedes ability to live independently?**     Yes     No     Client doesn't know     Client prefers not to answer

Disability Type	(If Yes) Start Date	Will the Condition be long term?	Disability Determination		If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	
<b>Alcohol Use Disorder</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
Notes: _____						
<b>Chronic Health Condition</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
Notes: _____						
<b>Developmental Disability</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
Notes: _____						
<b>Drug Use Disorder</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
Notes: _____						
<b>HIV/AIDS</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
Notes: _____						
<b>Mental Health Disorder</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
Notes: _____						
<b>Physical Disability</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
Notes: _____						