HUD CoC & ESG Entry SO ES SH with ESHAP 2020

Please complete one sheet for each person served, whether they are an individual or a family member

Project Start Date: _____/_____/_____ **Project Name:** _____

S**ervicePointClient ID** _____

First Name: _____ **MI**: _____ **Last Name**: _____ **Suffix**: _____

Name Type:
- ❑ Full Name Reported
- ❑ Partial, Street Name, or Code Name Reported
- ❑ Client Doesn't Know
- ❑ Client Refused
- ❑ Data Not Collected

SSN: _____ – _____ – _____ **SSN Type:**
- ❑ Full
- ❑ Approximate/Partial
- ❑ Client Doesn't Know
- ❑ Client Refused
- ❑ Data Not Collected

U.S. Military Veteran? (Clients 18 and older): ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑Data Not Collected

HUD CoC & ESG Entry SO ES SH 2020

DOB (mm/dd/yyyy) ____/____/_____ **DOB Type:**
- ❑ Full DOB
- ❑ Approximate or Partial DOB
- ❑ Client Doesn't Know
- ❑ Client Refused
- ❑ Data Not Collected

Primary Race:
- ❑American Indian or Alaska Native
- ❑ Asian
- ❑ Black/African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ Client Doesn't know
- ❑ Client Refused
- ❑ Data Not Collected

Secondary Race:
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black/African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ Client Doesn't know
- ❑ Client Refused
- ❑ Data Not Collected

Ethnicity:
- ❑ Hispanic/Latino
- ❑ Non-Hispanic /Latino)
- ❑ Client Doesn't Know
- ❑ Client Refused
- ❑ Data Not Collected

Gender:
- ❑ Female
- ❑ Male
- ❑ Trans Male {FTM or female to male}
- ❑ Trans Female {MTF male to female}
- ❑ Gender non-conforming {IE not exclusively male or female}
- ❑ Client Doesn't Know
- ❑ Client Refused
- ❑ Data Not Collected

Does the client have a disabling condition? ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑Data Not Collected

Relationship to Head of Household:
- ❑ Self
- ❑ Head of Household's Child
- ❑ Head of Household's Spouse or Partner
- ❑ Other Relation to Head of Household
- ❑ Other Non-Related Member
- ❑ Data Not Collected

Prior Living Situation:

-HOMELESS SITUATION-
- ❑ Place Not Meant for Habitation
- ❑ Emergency Shelter, including hotel/motel paid for w/ES voucher, or RHY-funded host home shelter
- ❑ Safe Haven

-INSTITUTIONAL SITUATION-
- ❑ Foster Care Home or Foster Care Group Home
- ❑ Hospital or other Residential Non-Psychiatric Medical Facility
- ❑ 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

-TEMPORARY AND PERMANENT HOUSING SITUATION-
- ❑ Residential Project or Halfway House with no Homeless Criteria
- ❑ Hotel or Motel Paid for without an Emergency Shelter Voucher
- ❑ Transitional Housing for Homeless Persons (includes homeless youth)
- ❑ Host Home (non-crisis)
- ❑ 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
- ❑ Rental by Client, with VASH Subsidy
- ❑ Permanent Housing (other than RRH) for Formerly Homeless Persons
- ❑ 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, No Ongoing Housing Subsidy
- ❑ Rental by Client, with Other Ongoing Housing Subsidy
- ❑ Owned by Client, with Ongoing Housing Subsidy
- ❑ Owned by Client, No Ongoing Housing Subsidy

-OTHER-
- ❑ Client Doesn't Know
- ❑ Client Refused
- ❑ Data Not Collected

Length of stay in previous living situation:
- ❑ 1 night or less
- ❑ 2 to 6 night's
- ❑ 1 week or more but less than 1 month
- ❑ 1 month or more but less than 90 day's
- ❑ 90 days or more but less than 1 year
- ❑ 1 year or longer
- ❑ Client Doesn't Know
- ❑ Client Refused
- ❑ Data Not Collected

Approximate Date Homelessness Started: _____/_____/_____

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:

- ❑ One Time
- ❑ Two Times
- ❑ Three Times
- ❑ Four or More Times
- ❑ Client Doesn't Know
- ❑ Client Refused
- ❑ Data Not Collected

Total Number of Months Homeless on the street, in ES or SH in the Past Three Years:

- ❑ One Month (this time is the first month)
- ❑ 2 Months
- ❑ 3 Months
- ❑ 4 Months
- ❑ 5 Months
- ❑ 6 Months
- ❑ 7 Months
- ❑ 8 Months
- ❑ 9 Months
- ❑ 10 Months
- ❑ 11 Months
- ❑ 12 Months
- ❑ More than 12 Months
- ❑ Client Doesn't Know
- ❑ Client Refused
- ❑ Data Not Collected

Income from any source? ❑ Yes ❑ No ❑Client Doesn't Know ❑Client Refused ❑Data Not Collected

Monthly Income

Receiving Income	Source of Income (*Check all that apply)*	Income Amount
❑Yes ❑No	Earned Income	$
❑Yes ❑No	Unemployment Insurance	$
❑Yes ❑No	Supplemental Security Income (SSI)	$
❑Yes ❑No	Social Security Disability Income (SSDI)	$
❑Yes ❑No	VA Service Connected Disability Compensation	$
❑Yes ❑No	Private Disability Insurance	$
❑Yes ❑No	Worker's Compensation	$
❑Yes ❑No	Temporary Assistance for Needy Families (TANF)	$
❑Yes ❑No	General Assistance	$
❑Yes ❑No	Retirement Income From Social Security	$
❑Yes ❑No	VA Non-Service Connected Disability Pension	$
❑Yes ❑No	Pension or Retirement Income from Another Job	$
❑Yes ❑No	Child Support	$
❑Yes ❑No	Alimony or Other Spousal Support	$
❑Yes ❑No	Other – Specify Source _____	$
	Total Monthly Income	Total:

Non-Cash Benefit from any source? ❑ Yes ❑ No ❑Client Doesn't Know ❑Client Refused ❑Data Not Collected

Non-Cash Benefits

Receiving Benefit	Source of Non-Cash Benefit (*Check all that apply)*	Benefit Amount *(when applicable)*
❑Yes ❑No	Supplemental Nutrition Assistance Program (SNAP – Food Stamps)	$
❑Yes ❑No	Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	$
❑Yes ❑No	TANF Child Care services	$
❑Yes ❑No	TANF Transportation services	$
❑Yes ❑No	Other TANF-funded services	$
❑Yes ❑No	Other Source – Specify Source _____	$

Covered by Health Insurance? ❑Yes ❑ No ❑Client Doesn't Know ❑Client Refused ❑Data Not Collected

Health Insurance

Covered	Health Insurance Type (*Check all that apply)*
❑Yes ❑No	MEDICAID
❑Yes ❑No	MEDICARE
❑Yes ❑No	State Children's Health Insurance Program
❑Yes ❑No	Veteran's Administration (VA) Medical Services
❑Yes ❑No	Employer-Provided Health Insurance
❑Yes ❑No	Health Insurance obtained through COBRA
❑Yes ❑No	Private Pay Health Insurance
❑Yes ❑No	State Health Insurance for Adults
❑Yes ❑No	Indian Health Services Program
❑Yes ❑No	Other – Specify: _____

Health, Substance Abuse, and Disabilities

Disability Type	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently
Physical ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑ DNC	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑ DNC
Developmental ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑ DNC	**Not Required** ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑ DNC
Chronic Health Condition ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑ DNC	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑ DNC
HIV/AIDS ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑ DNC	**Not Required** ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑ DNC
Mental Health Problem ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑ DNC	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑ DNC
Alcohol Abuse ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑ DNC	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑ DNC
Drug Abuse ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑ DNC	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑ DNC
Both Alcohol and Drug Abuse ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑ DNC	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑ DNC

Domestic violence victim/survivor?
- ❑ Yes
- ❑ No
- ❑ Client Doesn't Know
- ❑ Client Refused
- ❑ Data Not Collected

If yes, how long ago?
- ❑ Within the past three months
- ❑ Three to six months ago
- ❑ From six to twelve months ago
- ❑ More than a year ago
- ❑ Client Doesn't know
- ❑ Client Refused

If yes, are you currently fleeing?
- ❑ Yes
- ❑ No
- ❑ Client Doesn't Know
- ❑ Client Refused
- ❑ Data Not Collected

Maine Required Assessment:

Zip Code of Last Permanent Address: _____

Zip data quality for last permanent address: ❑Full or Partial Zip Code Report ❑Client doesn't know ❑Client refused

Release of Information Date: _____/_____/_____

Type of Release: ❑None ❑Signed by Client ❑Verbal

Client Signature: _____ ..... Date: _____