HUD CoC & ESG for ESHAP Update 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**: _____

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	$

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 _____	$

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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

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

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

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

ESHAP Required Fields

Current number of clients in household (including head of household): _____

Initial Housing Stability Plan Completed? ❑ Yes ❑ No

Initial Housing Stability Plan Date: _____/_____/_____

Housing Stability Plan Update Date: _____/_____/_____

Did you complete services this month? ❑ Yes ❑ No

Last Service Date: _____/_____/_____

End of Program Participation Date: _____/_____/_____

Maine Required Assessment:

VI-SPDAT

VI-SPDAT Date: _____/_____/_____
VI-SPDAT Score: (1-20 or 33) _____
VI-SPDAT Type: ❑Family ❑Individual ❑Teen