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

**Project Start Date:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ Project **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Community Services Client ID** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**First Name: MI**: **Last Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Suffix**: \_­­\_\_\_\_\_\_\_\_\_\_

**Income from any source?** Yes No Client Doesn’t Know Client Prefers not to Answer 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** | **$** |

**Start Date: \_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Non-Cash Benefit from any source?** Yes No Client Doesn’t Know  Client Prefers not to Answer 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | $ |

**Start Date: \_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Covered by Health Insurance?** Yes No Client Doesn’t Know  Client Prefers not to Answer 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Start Date: \_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health, Substance Use, 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 Prefers not to Answer  DNC | Yes No Client Doesn’t Know  Client Prefers not to Answer  DNC |
| **Developmental**Yes No Client Doesn’t Know  Client Prefers not to Answer  DNC | **Not Required**YesNo Client Doesn’t Know  Client Prefers not to Answer  DNC |
| **Chronic Health Condition**Yes No Client Doesn’t Know  Client Prefers not to Answer  DNC | Yes No Client Doesn’t Know  Client Prefers not to Answer  DNC |
| **HIV/AIDS**Yes No Client Doesn’t Know  Client Prefers not to Answer  DNC | **Not Required**Yes No Client Doesn’t Know  Client Prefers not to Answer  DNC |
| **Mental Health Disorder**Yes No Client Doesn’t Know  Client Prefers not to Answer  DNC | Yes No Client Doesn’t Know  Client Prefers not to Answer  DNC |
| **Substance Use Disorder**No Alcohol Use DisorderDrug Use Disorder Both Alcohol and Drug Use DisordersClient Doesn’t Know  Client Prefers not to Answer  DNC | Yes No Client Doesn’t Know  Client Prefers not to Answer  DNC |

**Start Date: \_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Domestic violence victim/survivor?**  Yes  Client Prefers not to Answer

  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 Prefers not to Answer

**If yes, are you currently fleeing?**  Yes  Client Prefers not to Answer

  No  Data Not Collected

  Client Doesn’t Know

**Maine Required Assessment:**

**Zip Code of Last Permanent Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Zip data quality for last permanent address:**

 Full or Partial Zip Code Reported  Client doesn’t know  Client Prefers Not to Answer

**Release of Information Date:** \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**Type of Release:**  None  Signed by Client  Verbal

**Required for ESHAP Projects Only:**

**Is the household currently receiving housing navigation from another agency or enrolled in a program that is effectively helping them obtain/remain in safe stable housing such as another RRH program?**

 Yes  No

**CE Assessment completed?**

 Yes  No

**Client Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_