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**: \_­­\_\_\_\_\_\_\_\_\_\_

**Housing Move-in Date: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**

**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 | **Not Required**  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 | **Not Required**  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 | **Not Required**  Yes  No  Client Doesn’t Know  Client Prefers Not to Answer  DNC |
| **Alcohol Use Disorder**  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 |
| **Drug Use Disorder**  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 |
| **Both Alcohol and Drug Use Disorder**  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 |

**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

**Connection with SOAR:** YesNo