Form for Homeless Outreach

Name: _____ **Date:** _____/_____/_____

Social Security Number: _____-_____-_____**Date of Birth:**_____/_____/_____

Zip Code of Last Address: _____

Gender: ☐Male ☐Female ☐Transgender M2F ☐Transgender F2M ☐Other

Primary Race: ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐White

Secondary Race: ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐White

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Non-Latino

Is client ☐Single ☐Married ☐Divorced ☐Widowed

Does client have children ☐Yes how many live with you _____ ☐No

Applying for housing with anyone else ☐Yes whom/relationship _____ ☐No

Have or are interested in having a professional live-in caregiver ☐Yes ☐No

Does client have a disability of long duration? Select all that apply:

☐Alcohol Abuse ☐Dual Diagnosis ☐Mental Health
☐Drug Abuse ☐Hearing Impaired ☐Physical/Medical
☐Both Alcohol and Drug Abuse ☐HIV/AIDS ☐Physical
☐Developmental ☐Vision Impaired ☐Chronic Health Condition
☐Other: _____

Is client currently receiving services or treatment for any of these? Describe: _____

_____

Housing Status: ☐Literally Homeless ☐Imminently losing their housing
☐Unstably housed and at risk of losing their housing ☐Stably housed

Has client received any income from the following sources in the past 30 days? ☐Yes ☐No

Alimony	$	Retirement Disability	$
Alimony or Other Spousal Support	$	Retirement Income from Social Security	$
Annuities	$	Self-Employment Wages	$
Child Support	$	SSDI	$
Contributions from Other People	$	SSI	$
Dividends (Investments)	$	State Disability	$
Earned Income/Employment	$	TANF	$
General Assistance	$	Unemployment Insurance	$
Interest (Bank)	$	Veteran's Disability Payment	$
Pension/Retirement	$	Veteran's Pension	$
Private Disability Insurance	$	Worker's Compensation	$
Rental Income	$	Other	$

Total Monthly Income: $_____ ☐<50% AMI ☐<30% AMI

Has client received any non-cash benefits from the following sources in the past 30 days? ☐Yes ☐No

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Food Stamps	$	TANF Child Care Services	$
Special Supplemental Nutrition Program for WIC	$	TANF Transportation Services	$
Temporary Rental Assistance	$	Other TANF-Funded Services	$
Other Source	$	Section 8/Public Housing/Rental Assistance	$

Does client have a representative payee? ☐Yes ☐No

If yes, his (her) Name_____ **Phone number** _____

Email _____ **Address** _____

What was the client's prior living arrangement?

☐Emergency shelter
☐Foster home
☐Hospital (non-psychiatric)
☐Hotel/Motel (no voucher)
☐Jail/Prison/Juvenile detention
☐Owned by client (no subsidy)
☐Owned by client with subsidy
☐Permanent housing for formerly homeless
☐Place not meant for habitation
☐Psychiatric hospital
☐Rental by client (no subsidy)
☐Rental by client with non-VASH subsidy
☐Rental by client with VASH
☐Safe haven
☐Family member's room/apartment/house
☐Friend's room/apartment/house
☐Substance abuse treatment facility/Detox
☐Transitional housing facility

Approximate start date at previous residence? _____ / _____ / _____
Mon. Day Year

Length of stay in previous place?

☐One day or less
☐Two days to one week
☐More than one week, but less than one month
☐One to three months
☐More than three months, but less than one year
☐One year or longer

Number of times the client has been on the streets, in emergency shelters or supportive housing in the past three years, including today?

☐Never in the 3 years
☐One time
☐Two times
☐Three times
☐Four or more times

Ever been evicted? ☐Yes, what were the circumstances _____
_____ ☐No

On the sex offender registry? ☐Yes ☐No

Convicted of manufacturing or selling methamphetamine? ☐Yes ☐No

Convicted of arson? ☐Yes ☐No

Convicted of a felony? ☐Yes, type/year _____ ☐No

Total number of months homeless on the street, in emergency shelters or supportive housing in the past three years?

☐One month (this is the 1st month) ☐4 months ☐7 months ☐10 months

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☐2 months ☐5 months ☐8 months ☐11 months
☐3 months ☐6 months ☐9 months ☐12 months
☐More than 12 months

Does the client have health insurance? ☐Yes ☐No

If yes, which of the following:

☐State Health Insurance For Adults (MediCal/CenCal)
☐Medicaid
☐Medicare
☐State Children's Health Insurance Program
☐Veteran's Administration (VA) Medical Services
☐Employer-Provided Health Insurance
☐Health Insurance Obtain Through COBRA
☐Private Pay Health Insurance

Is the client currently affected by a disaster? ☐Yes ☐No

Is the client a U.S. military veteran? ☐Yes ☐No
Did client serve on active duty? ☐Yes ☐No **Enlist or Officer**
Service Start Date: _____/_____/_____ **Service End Date:** _____/_____/_____
Did client serve in the Reserves? ☐Yes ☐No **Enlist or Officer**
Service Start Date: _____/_____/_____ **Service End Date:** _____/_____/_____
Did client serve in the State National Guard? ☐Yes ☐No **Enlist or Officer**
Service Start Date: _____/_____/_____ **Service End Date:** _____/_____/_____
Did client serve in a War Zone? ☐Yes ☐No

Is client a veteran family member? ☐Yes ☐No **Is client a military family member?** ☐Yes ☐No
Did client serve in a War Zone? ☐Yes ☐No
Military Branch: ☐Air Force ☐Army ☐Coast Guard ☐Marines ☐National Guard ☐Navy ☐Other
Discharge Type: ☐Honorable ☐General ☐Medical ☐Bad Conduct ☐Dishonorable ☐Other: _____

Emergency contact person name/phone/email/relation _____

_____

Do you have any pets or service animals? ☐Yes how many, what kind _____ ☐No

Do you have a vehicle? ☐Yes make/model/license plate _____
_____ ☐No
