

FSBH COORDINATED ASSESSMENT INTAKE FORM 2019

COORDINATED ASSESSMENT ENTRY DATE (e.g., 08/24/2018)

		/			/			
Month		Day			Year			

NAME (first, middle, last name, suffix (e.g., Jr, Sr, III))

First: _____ Middle: _____ Last Name _____

NAME DATA QUALITY

- Full name reported
- Partial, street name, or code name reported
- Client doesn't know
- Client refused

SOCIAL SECURITY NUMBER

			-			-			
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DATE OF BIRTH (e.g., 10/23/1978)

		/			/			
Month		Day			Year			

SOCIAL SECURITY NUMBER DATA QUALITY

- Full SSN reported
- Approximate or partial SSN reported
- Client doesn't know
- Client refused

DATE OF BIRTH TYPE

- Full date of birth reported
 - Approximate or partial date of birth reported
 - Client doesn't know
 - Client refused
-

GENDER

- Female
- Male
- Transgender male to female
- Transgender female to male

- Other _____
- Client doesn't know
- Client refused

RELATIONSHIP TO HEAD OF HOUSEHOLD

- Self (head of household)

MARITAL STATUS

- Single

- Other _____

CITIZENSHIP

- U.S. Citizen
- Ineligible Citizen

- Eligible non-citizen
- Undocumented

PRIMARY LANGUAGE

- English

- Other _____

ABILITY TO READ OR WRITE

- Yes

- Other _____

RACE

More than one race is permitted. *Client doesn't know* and *Client refused* should only be selected if no other response is selected.

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander

- White
- Client doesn't know
- Client refused

ETHNICITY

- Non-Hispanic / Non-Latino
- Hispanic / Latino

- Client doesn't know
- Client refused

VETERAN

yes

no

CURRENT ADDRESS

Street: _____

City: _____

Zip Code: _____

County: _____

Phone: cell home work _____

Email: _____

ADD FAMILY MEMBERS- You will need to fill out the above information on each additional family member.

Name

DOB SSN

Relationship

Race Ethnicity

HUD UNIVERSAL DATA ELEMENTS

DISABLING CONDITION: No Yes Client Doesn't know Client Refused Data not collected

LIVING SITUATION

Type of Residence

- | | |
|--|---|
| <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher | <input type="checkbox"/> Foster Care/Group Home |
| <input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) | <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility |
| <input type="checkbox"/> Safe Haven | <input type="checkbox"/> Jail, prison, or juvenile detention facility |
| <input type="checkbox"/> Interim Housing | <input type="checkbox"/> Rental by client, with no other ongoing housing subsidy |
| <input type="checkbox"/> Long-term care facility or nursing home | <input type="checkbox"/> Rental by client, with other ongoing housing subsidy |
| <input type="checkbox"/> Psychiatric hospital or other psychiatric facility | <input type="checkbox"/> Staying or living in a family member's room, apartment, or house |
| <input type="checkbox"/> Substance abuse treatment facility or detox center | <input type="checkbox"/> Staying or living in a friend's room, apartment, or house |
| <input type="checkbox"/> Motel w/o voucher | <input type="checkbox"/> Transitional Housing for homeless person including youth |
| <input type="checkbox"/> Owned by client no ongoing subsidy | <input type="checkbox"/> Rental w/VASH |
| <input type="checkbox"/> Permanent Housing for formerly homeless persons | <input type="checkbox"/> Rental by client, with GPD TIP subsidy |
| <input type="checkbox"/> Rental project or halfway house w/no homeless criteria | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Client refused | <input type="checkbox"/> Data not collected |

Approximate date homelessness started

		/			/				
Month			Day			Year			

HEALTH INSURANCE ASSESSMENT

Answer 'Yes' or 'No' for each health insurance source.

Answer 'No' for sources that have been terminated, even if they were received in the past.

No	Yes	Source of non-cash benefit
<input type="checkbox"/>	<input type="checkbox"/>	Medicaid
<input type="checkbox"/>	<input type="checkbox"/>	Medicare
<input type="checkbox"/>	<input type="checkbox"/>	State Children's Health Insurance Program (MO Healthnet or Healthcare USA)
<input type="checkbox"/>	<input type="checkbox"/>	Veteran's Administration (VA) Medical Services
<input type="checkbox"/>	<input type="checkbox"/>	Employer-Provided Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	Health insurance obtained through COBRA
<input type="checkbox"/>	<input type="checkbox"/>	Private Pay Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	State Health Insurance for Adults (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Other: Specify

HUD FINANCIAL ASSESSMENT

INCOME FROM ANY SOURCE

No

Yes

Client Doesn't know

Client Refused

[IF YES] Answer Yes or No for each income source. If the response for a source is 'Yes', enter the monthly amount received based on current income. If unsure of the exact monthly amount, enter client's best estimate.

Source of income	Weekly Amt.	Monthly Amt.
Unemployment Income	<input type="checkbox"/>	<input type="checkbox"/>
Earned income (i.e., employment income)	<input type="checkbox"/>	<input type="checkbox"/>
Supplemental Security Income (SSI)	<input type="checkbox"/>	<input type="checkbox"/>
Social Security Disability Income (SSDI)	<input type="checkbox"/>	<input type="checkbox"/>
VA Services Connected to Disability Comp.	<input type="checkbox"/>	<input type="checkbox"/>
Private Disability Insurance	<input type="checkbox"/>	<input type="checkbox"/>
TANF	<input type="checkbox"/>	<input type="checkbox"/>
General Assistance (GA)	<input type="checkbox"/>	<input type="checkbox"/>
Retirement from Social Security	<input type="checkbox"/>	<input type="checkbox"/>
VA Non-Services Pension	<input type="checkbox"/>	<input type="checkbox"/>
Pension/Retirement from former job	<input type="checkbox"/>	<input type="checkbox"/>
Child support	<input type="checkbox"/>	<input type="checkbox"/>
Alimony/Other spousal support	<input type="checkbox"/>	<input type="checkbox"/>
Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>
Other source	<input type="checkbox"/>	<input type="checkbox"/>
Total monthly income	\$	

TRANSPORTATION

Public

None

Bike

Own Car

Relative/Friend

Community Information Sharing System (CISS)

Client Consent Form

The information that is collected in the MO-503 CISS is protected by limiting access to the database and by limiting with whom the information may be shared, in compliance with applicable federal and state laws. Every person and organization that is authorized to read or enter information into the database has signed an agreement to maintain the security and confidentiality of the information. Any person or organization that is found to violate that agreement may have their access rights terminated and may be subject to further penalties.

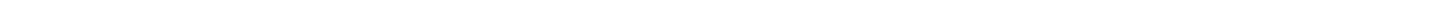
FOR DATA BEING ENTERED INTO THE CISS I UNDERSTAND THAT:

- Staff of other service organizations and others authorized to access the CISS who may see my information have promised to protect it.
- Partner Organizations may share general information that does not identify me to others.
- I understand the information in the CISS may include my financial situation, historical information about me and members of my household, and certain health information.
- I have the right to request information about who has looked at my file.
- I have the right to review confidentiality policies relating to the CISS.
- I may withdraw my consent at any time. Information already in the database will remain, but no new information will be entered. Identifying information will be hidden.

Head of Household Client Name Client Signature Date

(Please print)

Staff *(please print)* Staff Signature Date



Monthly Income Source	Amount	Who Receives
Alimony	\$	
Child Support	\$	
Earned Income	\$	
Earned Income	\$	
Earned Income	\$	
Government Assistance	\$	
Pension	\$	
Railroad	\$	
Retirement SS	\$	
Social Security Disability (SSDI)	\$	
Social Security Income (SSI)	\$	
TANF	\$	
Unemployment	\$	
Veterans Disability	\$	
Veterans Pension	\$	
Workmen's Compensation	\$	
Other Source	\$	
Non-Cash Benefits	Amount	Who Receives

Food Stamps	\$	
Medicaid	Yes/No	
Medicare	Yes / No	
Section 8	\$	
TANF Child Care	\$	
TANF Transportation	\$	
VA Insurance	Yes / No	
WIC	Yes / No	
HUD Housing	\$	
Other		
Other TANF		
USDA	Yes/No	

Expense	Monthly Cost	Amount Past Due
Auto fuel	\$	\$
Auto Ins.	\$	\$
Auto Payment	\$	\$
Cable	\$	\$
Charitable Donations/ Tithe	\$	\$
Child Care	\$	\$
Child Support	\$	\$

Credit Cards	\$	\$
Electric	\$	\$
Food	\$	\$
Gas/propane	\$	\$
Household Goods	\$	\$
Home Ins.	\$	\$
Legal Fees	\$	\$
Loans	\$	\$
Lot Rent	\$	\$
Medical Ins	\$	\$
Medicine	\$	\$
Mortgage	\$	\$
Personal care	\$	\$
Phone bills	\$	\$
Rent	\$	\$
Taxes	\$	\$
Trash	\$	\$
Water, Sewer	\$	\$

Total debt \$ _____

Today's date _____

Monthly payment made to reduce debt

\$ _____