Client ID # _____ FSBH COORDINATED ASSESSMENT INTAKE FORM 2021

COORDINATED ASSESSMENT ENTRY DATE (e.g., 08/24/2014)

		/			/				
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

			-			-				

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	☐	Eligible non-citizen
☐	Ineligible 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	☐	White
☐	Asian	☐	Client doesn't know
☐	Black or African American	☐	Client refused
☐	Native Hawaiian or Other Pacific Islander		

ETHNICITY

☐	Non-Hispanic / Non-Latino	☐	Client doesn't know
☐	Hispanic / Latino	☐	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

☐	Emergency shelter, including hotel or motel paid for with emergency shelter voucher	☐	Foster Care/Group Home
☐	Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)	☐	Hospital or other residential non-psychiatric medical facility
☐	Safe Haven	☐	Jail, prison, or juvenile detention facility

☐	Interim Housing	☐	Rental by client, with no other ongoing housing subsidy
☐	Long-term care facility or nursing home	☐	Rental by client, with other ongoing housing subsidy
☐	Psychiatric hospital or other psychiatric facility	☐	Staying or living in a family member's room, apartment, or house
☐	Substance abuse treatment facility or detox center	☐	Staying or living in a friend's room, apartment, or house
☐	Motel w/o voucher	☐	Transitional Housing for homeless person including youth
☐	Owned by client no ongoing subsidy	☐	Rental w/VASH
☐	Permanent Housing for formerly homeless persons	☐	Rental by client, with GPD TIP subsidy
☐	Rental project or halfway house w/no homeless criteria	☐	Client doesn't know
☐	Client refused	☐	Data not collected

Length of Stay

☐	One night or less	☐	90 days or more but less than one year
☐	Two nights to six nights	☐	One year or more
☐	More than one week, but less than one month	☐	Client doesn't know
☐	One month or more but less than 90 days	☐	Client refused

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
☐	☐	Medicaid
☐	☐	Medicare
☐	☐	State Children's Health Insurance Program (MO Healthnet or Healthcare USA)
☐	☐	Veteran's Administration (VA) Medical Services
☐	☐	Employer-Provided Health Insurance
☐	☐	Health insurance obtained through COBRA
☐	☐	Private Pay Health Insurance
☐	☐	State Health Insurance for Adults (or use local name)
☐	☐	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	☐		☐
Earned income (i.e., employment income)	☐		☐
Supplemental Security Income (SSI)	☐		☐
Social Security Disability Income (SSDI)	☐		☐
VA Services Connected to Disability Comp.	☐		☐
Private Disability Insurance	☐		☐
TANF	☐		☐
General Assistance (GA)	☐		☐
Retirement from Social Security	☐		☐
VA Non-Services Pension	☐		☐
Pension/Retirement from former job	☐		☐
Child support	☐		☐
Alimony/Other spousal support	☐		☐
Worker's Compensation	☐		☐
Other source	☐		☐
Total monthly income	**$**		

TRANSPORTATION

☐ Public	☐ None
☐ Bike	☐ Own Car
☐ Relative/Friend	

St. Charles, Lincoln, & Warren
Continuum of Care

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 *(Please print)*	Client Signature	Date

_____	_____	_____
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

$_____