

3.1 Project Start Assessment - ES

This form should be used by Emergency Shelter Projects for every client. (children pages 1-2; all adults pages 1-8; heads of household pages 1-9)

ANSWER FOR ALL HOUSEHOLD MEMBERS

DATE OF PROJECT START									
		/			/				
Month		Day			Year				

HMIS CLIENT ID - For HMIS Users only									

NAME - (First, Middle, Last, Suffix)	
First Name	
Middle Name	
Last Name	
Suffix (e.g., Jr, Sr, III)	

NAME DATA QUALITY
<input type="checkbox"/> Full name reported
<input type="checkbox"/> Partial, street name or code name
<input type="checkbox"/> Client doesn't know (CDK)
<input type="checkbox"/> Client refused (CR)
<input type="checkbox"/> Data Not Collected (DNC)

SOCIAL SECURITY NUMBER	Data Quality Status				
	<input type="checkbox"/> Full Reported	<input type="checkbox"/> Approx. or Partial Reported	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

VETERAN STATUS					
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected	

DATE OF BIRTH (e.g. 10/23/1978)	Data Quality Status				
	<input type="checkbox"/> Full Reported	<input type="checkbox"/> Approx. or Partial Reported	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

GENDER - Select or more gender identities	
<input type="checkbox"/> Female	<input type="checkbox"/> Questioning
<input type="checkbox"/> Male	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> A gender other than singularly female or male (e.g. non-binary, genderfluid, agender, culturally specific gender)	<input type="checkbox"/> Client refused
<input type="checkbox"/> Transgender	<input type="checkbox"/> Data not collected

PRIMARY RACE - Select one or more race categories	
<input type="checkbox"/> American Indian, Alaska Native, or Indigenous	<input type="checkbox"/> White
<input type="checkbox"/> Asian or Asian American	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Black, African American, or African	<input type="checkbox"/> Client refused
<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Data not collected

ETHNICITY	
<input type="checkbox"/> Non-Hispanic / Non-Latin(a)(o)(x)	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Hispanic / Latin(a)(o)(x)	<input type="checkbox"/> Client refused
	<input type="checkbox"/> Data not collected

RELATIONSHIP TO HEAD OF HOUSEHOLD	
<input type="checkbox"/> Self (head of household)	<input type="checkbox"/> Head of household's other relation member (other relation to head of household)
<input type="checkbox"/> Head of household's child	<input type="checkbox"/> Other: non-relation member
<input type="checkbox"/> Head of household's spouse or partner	<input type="checkbox"/> Data not collected

DISABILITY STATUS - Does the client have a disabling condition?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected
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Answer 'Yes' or 'No' for each disability type (in white).
 If the client selects 'Yes' for any disability type, you must also complete the shaded sections below.

Disability Type	Yes	No	Disability Determination	Expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently?	Start Date (MM/DD/YYYY)
Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	
Chronic Health Con	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	
Developmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	
Alcohol Use Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	
Substance Use Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	
Both Alcohol & Drug Use Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	
Mental Health Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	

HEALTH INSURANCE - Is the client currently covered by health insurance?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected
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Answer 'Yes' or 'No' for each health insurance source.
 Answer 'Yes' for any source that is currently received.
 Answer 'No' for sources that have been terminated, even if they were received in the past.
 If the client selects 'Yes' for any insurance type, complete the shaded section below.

Health Insurance Type	Yes	No	Start Date (MM/DD/YYYY)
MEDICAID	<input type="checkbox"/>	<input type="checkbox"/>	
MEDICARE	<input type="checkbox"/>	<input type="checkbox"/>	
State Children's Health Insurance Program (or North Carolina Health Choice)	<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	<input type="checkbox"/>	<input type="checkbox"/>	
Indian Health Services Program	<input type="checkbox"/>	<input type="checkbox"/>	
Other If Yes, specify source:	<input type="checkbox"/>	<input type="checkbox"/>	

NC COUNTY OF SERVICE In which NC county is this client receiving your project's services?	
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What is the ZIP CODE of the client's last permanent address?	
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ANSWER THESE QUESTIONS FOR HEAD OF HOUSEHOLD AND OTHER ADULTS

CLIENT LOCATION – In which CoC is the Head of Household staying at the time of project entry?			
<input type="checkbox"/> NC 502-Durham City & County	<input type="checkbox"/> NC 503-NC Balance of State	<input type="checkbox"/> NC 513-Chapel Hill/Orange County	<input type="checkbox"/> Other:

HOMELESS HISTORY

TYPE OF PRIOR LIVING SITUATION - Where was the client living immediately prior to this project entry?

Homeless	<input type="checkbox"/> Place not meant for habitation <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher
Institutional	<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison, or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center
Temporary and Permanent	<input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Rental by client, with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy
Other	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

LENGTH OF STAY IN PRIOR LIVING SITUATION - How long was the client staying in that place?

<input type="checkbox"/> 1 night or less	<input type="checkbox"/> 1 year or longer
<input type="checkbox"/> 2 to 6 nights	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> 1 week or more, but less than 1 month	<input type="checkbox"/> Client refused
<input type="checkbox"/> 1 month or more, but less than 90 days	<input type="checkbox"/> Data not collected
<input type="checkbox"/> 90 days or more, but less than 1 year	

APPROXIMATE DATE THIS HOMELESSNESS STARTED – When did the client start staying on the street, or in ES this time?

			/			/				
Month			Day			Year				

Regardless of where the client stayed last night, HOW MANY TIMES has the client been homeless on the streets, or in shelter in the past 3 years including today?	
<input type="checkbox"/> One time (Select this answer if this is the 1 st time the client has been homeless in the past 3 years)	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Two times	<input type="checkbox"/> Client refused
<input type="checkbox"/> Three times	<input type="checkbox"/> Data not collected
<input type="checkbox"/> Four or more times	

HOW MANY MONTHS, in total, has the client been homeless on the street, or in an emergency shelter the past 3 years?	
<input type="checkbox"/> 1 month or less (Select this answer if this is the 1 st time the client has been homeless in the past 3 years)	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Between 2 and 12 Months → Enter the total number of months:	<input type="checkbox"/> Client refused
<input type="checkbox"/> More than 12 months	<input type="checkbox"/> Data not collected

INCOME AND SOURCES - Does the client currently have any income from any source?				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

To complete the table below, you must answer 'Yes' or 'No' for each income source.

Answer 'Yes' only if the income source is recurrent and received as of today (i.e. not terminated).

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

If the response for any source is 'Yes', complete the shaded sections below.

Enter the start date and monthly amount received. If unsure of the exact amount, enter the client's best estimate.

Children's income (except earned income) can be included under the Head of Household's information.

Source of Income	Yes	No	If yes, monthly amount from source (round to nearest dollar)	Start Date (MM/DD/YYYY)
Earned income (i.e., employment income)	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Unemployment Insurance	<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 Service-Connected Disability Compensation	<input type="checkbox"/>	<input type="checkbox"/>	\$	
VA Non-Service-Connected Disability Pension	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Private disability insurance	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Temporary Assistance for Needy Families (TANF)	<input type="checkbox"/>	<input type="checkbox"/>	\$	
General Assistance (GA)	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Retirement Income from Social Security	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Pension or retirement income from a former job	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Child support	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Alimony or other spousal support	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Other source:	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Total monthly income from all sources			\$	

Continued on page 5

NON-CASH BENEFITS - Does the client have any non-cash benefits from any source?				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

To complete the table below, you must answer 'Yes' or 'No' for each non-cash benefit.
 Answer 'Yes' only if the non-cash benefit is recurrent and received as of today (i.e. not terminated).
 Answer 'No' for non-cash benefit that have been terminated, even if they were received in the past.
If the response for any non-cash benefit is 'Yes', complete the shaded section.

Source of Non-Cash Benefit	Yes	No	If yes, monthly amount from source (round to nearest dollar)	Start Date (MM/DD/YYYY)
Supplemental Nutrition Assistance Program (SNAP)	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<input type="checkbox"/>	<input type="checkbox"/>	\$	
TANF Child Care services (or use local name)	<input type="checkbox"/>	<input type="checkbox"/>	\$	
TANF transportation services (or use local name)	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Other TANF-Funded Services (or use local name)	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Other source:	<input type="checkbox"/>	<input type="checkbox"/>	\$	

DOMESTIC VIOLENCE - Is client a domestic violence victim/survivor?				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

↓

If YES, When did the experience occur?	
<input type="checkbox"/> Within the past three months	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Three to six months ago (excluding six months exactly)	<input type="checkbox"/> Client refused
<input type="checkbox"/> Six months to one year ago (excluding one year exactly)	<input type="checkbox"/> Data not collected
<input type="checkbox"/> One year ago or more	

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If YES, Is the client currently fleeing?				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

CURRENT LIVING SITUATION									
When was this contact with the client?									
				/			/		

TYPE OF CURRENT LIVING SITUATION - Where was the client living during this contact with the client?	
If the response is an Institutional, Temporary, or Permanent situation, follow-up questions are listed below.	
Homeless	<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"/> Emergency shelter, including hotel or motel paid for <i>with</i> emergency shelter voucher, or RHY-funded Host Home shelter
Institutional	<input type="checkbox"/> Foster care home or foster care group home
	<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility
	<input type="checkbox"/> Jail, prison, or juvenile detention facility
	<input type="checkbox"/> Long-term care facility or nursing home
	<input type="checkbox"/> Psychiatric hospital or other psychiatric facility
	<input type="checkbox"/> Substance abuse treatment facility or detox center
Temporary and Permanent	<input type="checkbox"/> Residential project or halfway house with no homeless criteria
	<input type="checkbox"/> Hotel or motel paid for <i>without</i> emergency shelter voucher
	<input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)
	<input type="checkbox"/> Host Home (non-crisis)
	<input type="checkbox"/> Staying or living in a friend's room, apartment or house
	<input type="checkbox"/> Staying or living in a family member's room, apartment or house
	<input type="checkbox"/> Rental by client, with GPD TIP housing subsidy
	<input type="checkbox"/> Rental by client, with VASH housing subsidy
<input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons	

	<input type="checkbox"/> Rental by client, with RRH or equivalent subsidy
	<input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based)
	<input type="checkbox"/> Rental by client in a public housing unit
	<input type="checkbox"/> Rental by client, no ongoing housing subsidy
	<input type="checkbox"/> Rental by client, with other ongoing housing subsidy
	<input type="checkbox"/> Owned by client, no ongoing housing subsidy
	<input type="checkbox"/> Owned by client, with ongoing housing subsidy
Other	<input type="checkbox"/> Other (specify):
	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Client refused
	<input type="checkbox"/> Data not collected
Living Situation verified by: Name the verifying agency and project	

IF INSTITUTIONAL, TEMPORARY, OR PERMANENT CURRENT LIVING SITUATION Is client going to have to leave their current living situation within 14 days?				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

↓

IF YES to, "is client going to have to leave their current living situation within 14 days?"				
Answer all	Has a subsequent residence been identified?			
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
	Does individual or family have resources or support networks to obtain other permanent housing?			
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
	Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	
Has the client moved 2 or more times in the last 60 days?				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	

CURRENT LIVING SITUATION - Location details

NC NATURAL DISASTER/STORM – Are you experiencing homelessness due to a recent natural disaster/storm?				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

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If YES: There are resources and partners available during natural disasters/storms that can help you. Do we have your permission to use this information to coordinate with them to help get you resources and assistance?				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

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If YES: What natural disaster/storm caused you to evacuate and seek other shelter?			
<input type="checkbox"/> Hurricane Florence	<input type="checkbox"/> Hurricane Matthew	<input type="checkbox"/> Hurricane Dorian	<input type="checkbox"/> Other:

What NC County were you living in immediately prior to the natural disaster/storm?	
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TYPE OF PRIOR LIVING SITUATION – What was your living situation immediately prior to the natural disaster/storm?	
Homeless	<input type="checkbox"/> Place not meant for habitation
	<input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher

Institutional	<input type="checkbox"/> Foster care home or foster care group home
	<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility
	<input type="checkbox"/> Jail, prison, or juvenile detention facility
	<input type="checkbox"/> Long-term care facility or nursing home
	<input type="checkbox"/> Psychiatric hospital or other psychiatric facility
	<input type="checkbox"/> Substance abuse treatment facility or detox center
Temporary and Permanent	<input type="checkbox"/> Residential project or halfway house with no homeless criteria
	<input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher
	<input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)
	<input type="checkbox"/> Host Home (non-crisis)
	<input type="checkbox"/> Staying or living in a friend's room, apartment or house
	<input type="checkbox"/> Staying or living in a family member's room, apartment or house
	<input type="checkbox"/> Rental by client, with GPD TIP housing subsidy
	<input type="checkbox"/> Rental by client, with VASH housing subsidy
	<input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons
	<input type="checkbox"/> Rental by client, with RRH or equivalent subsidy
	<input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based)
	<input type="checkbox"/> Rental by client in a public housing unit
	<input type="checkbox"/> Rental by client, no ongoing housing subsidy
	<input type="checkbox"/> Rental by client, with other ongoing housing subsidy
	<input type="checkbox"/> Owned by client, no ongoing housing subsidy
<input type="checkbox"/> Owned by client, with ongoing housing subsidy	
Other	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Client refused
	<input type="checkbox"/> Data not collected

LENGTH OF STAY – Before the natural disaster/storm, how long did you live in the prior living situation?

<input type="checkbox"/> 1 night or less	<input type="checkbox"/> 1 year or longer
<input type="checkbox"/> 2 to 6 nights	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> 1 week or more, but less than 1 month	<input type="checkbox"/> Client refused
<input type="checkbox"/> 1 month or more, but less than 90 days	<input type="checkbox"/> Data not collected
<input type="checkbox"/> 90 days or more, but less than 1 year	

APPROXIMATE DATE OF EVACUATION – On what date did you leave your prior living situation?

		/			/				
Month			Day			Year			

Do you know if the place you were living was destroyed by the natural disaster/storm, seriously damaged but not destroyed, or not seriously damaged?

<input type="checkbox"/> Destroyed	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Seriously damaged	<input type="checkbox"/> Client refused
<input type="checkbox"/> Not seriously damaged	<input type="checkbox"/> Data not collected

If the place you were living was destroyed or damaged in any way, do you have insurance to cover losses?

<input type="checkbox"/> I have insurance to cover most of my losses	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> I have insurance to cover some of my losses	<input type="checkbox"/> Client refused
<input type="checkbox"/> I have no insurance	<input type="checkbox"/> Data not collected

Have you registered with FEMA for assistance?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected
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If the place you were living was destroyed or damaged in any way, do you have insurance to cover losses?	
<input type="checkbox"/> I have insurance to cover most of my losses	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> I have insurance to cover some of my losses	<input type="checkbox"/> Client refused
<input type="checkbox"/> I have no insurance	<input type="checkbox"/> Data not collected

ANSWER THESE QUESTIONS FOR HEAD OF HOUSEHOLDS ONLY

COORDINATED ENTRY ASSESSMENT									
DATE OF ASSESSMENT	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%; border: none;">/</td> <td style="width: 15%;"></td> <td style="width: 15%; border: none;">/</td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> </table>			/		/			
		/		/					
ASSESSMENT LOCATION									
Orange CoC	<input type="checkbox"/> CEF								
	<input type="checkbox"/> Housing Helpline								
	<input type="checkbox"/> HomeLink								
	<input type="checkbox"/> IFC Commons								
	<input type="checkbox"/> Jail								
	<input type="checkbox"/> Medical Provider								
	<input type="checkbox"/> Outreach								
<input type="checkbox"/> Shelter									
BoS CoC	<input type="checkbox"/> Region 1								
	<input type="checkbox"/> Region 2								
	<input type="checkbox"/> Region 3								
	<input type="checkbox"/> Region 4								
	<input type="checkbox"/> Region 5								
	<input type="checkbox"/> Region 6								
	<input type="checkbox"/> Region 7								
	<input type="checkbox"/> Region 8								
	<input type="checkbox"/> Region 9								
	<input type="checkbox"/> Region 10								
	<input type="checkbox"/> Region 11								
	<input type="checkbox"/> Region 12								
	<input type="checkbox"/> Region 13								
ASSESSMENT TYPE	<input type="checkbox"/> Phone <input type="checkbox"/> In Person <input type="checkbox"/> Virtual								
ASSESSMENT LEVEL	<input type="checkbox"/> Crisis Needs Assessment <input type="checkbox"/> Housing Needs Assessment								
PRIORITIZATION STATUS	<input type="checkbox"/> Placed on Prioritization List <input type="checkbox"/> Not Placed on Prioritization List								

COORDINATED ENTRY EVENT														
START DATE / DATE OF EVENT							/			/				
EVENT														
Access Events	<input type="checkbox"/> Referral to Prevention Assistance project													
	<input type="checkbox"/> Problem Solving/Diversion/Rapid Resolution intervention or service							Go to A						
	<input type="checkbox"/> Referral to scheduled Coordinated Entry Crisis Needs Assessment													
	<input type="checkbox"/> Referral to scheduled Coordinated Entry Housing Needs Assessment							Go to B						
Referral Events	<input type="checkbox"/> Referral to post-placement/follow-up case management													
	<input type="checkbox"/> Referral to Street Outreach project or services													
	<input type="checkbox"/> Referral to Housing Navigation project or services													
	<input type="checkbox"/> Referral to Non-continuum services: Ineligible for continuum services													
	<input type="checkbox"/> Referral to Non-continuum services: No availability in continuum services													
	<input type="checkbox"/> Referral to Emergency Shelter bed opening							Go to C						
	<input type="checkbox"/> Referral to Transitional Housing bed/unit opening													
	<input type="checkbox"/> Referral to Joint TH-RRH project/unit/resource opening													
	<input type="checkbox"/> Referral to RRH project resource opening													
	<input type="checkbox"/> Referral to PSH project resource opening													
	<input type="checkbox"/> Referral to Other PH project/unit/resource opening													
	<input type="checkbox"/> Referral to emergency assistance/flex fund/furniture assistance													
	<input type="checkbox"/> Referral to Emergency Housing Voucher (EHV)													
<input type="checkbox"/> Referral to a Housing Stability Voucher														
If 'Event' answer was 'Problem Solving/Diversion/Rapid Re-Housing intervention or service result', please answer the following question:														
A. Problem Solving/Diversion/Rapid Resolution intervention or service result – Client housed/re-housed in a safe alternative?					<input type="checkbox"/> Yes							<input type="checkbox"/> No		
If 'Event' answer was 'Referral to post-placement/follow-up case management result', please answer the following question:														
B. Referral to post-placement/follow-up case management result – Enrolled in Aftercare project?					<input type="checkbox"/> Yes							<input type="checkbox"/> No		
If 'Event' answer was Referral to an ES, TH, Joint TH-RRH, RRH, PSH, or Other PH opening, please answer the following questions														
C. Location of Crisis Housing or Permanent Housing Referral (project name)														
D. Referral Result (if applicable)					<input type="checkbox"/> Client accepted		<input type="checkbox"/> Client rejected		<input type="checkbox"/> Provider rejected					
E. Date of Result (if applicable)							/			/				