Home Stretch is a project of the Alameda County Health Care Services Agency in collaboration with EveryOne Home and partnering agencies to help literally homeless individuals with disabilities, and their families, link with appropriate resources, services, and permanent housing as quickly as possible. Eligible individuals and households referred to Home Stretch are prioritized for access to services and permanent supportive housing resources in Alameda County based on their level of need and the length of time they have experienced homelessness. Home Stretch functions as a referral list for most permanent supportive housing programs in Alameda County. It does not operate as a waiting list for all affordable housing opportunities, so individuals and households referred to Home Stretch should get on waiting lists as they become open.

To be eligible, people must meet the following criteria at the time of referral:

- The individual (or head of household) is living on the streets, in abandoned buildings, parks, a vehicle, or other outside place not meant for people to live, in an emergency shelter or emergency housing program, or a transitional housing program for homeless individuals OR is in an institutional care facility for fewer than 90 days and was in one of the previously listed living situations prior to entering the institution; AND

- The individual (or head of household) has a disabling health condition(s), such as a diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, that is expected to be of long-continued and indefinite duration and substantially impedes the persons’ ability to live independently.

Individuals that meet one or both of the criteria below receive prioritized access to resources. Highest priority is given to individuals that meet both of the following criteria:

- The individual (or head of household) has been staying in a place not meant for human habitation or a shelter for more than one year continuously or four or more times over the past three years with more than 12 months of cumulative time living on the streets or in shelters; AND

- The individual (or head of household) has high priority needs as demonstrated by at least one of the following (see Home Stretch High Services Need Verification Form for details):
  - Frequent verified contact with health or law enforcement agencies over the last 12 months
  - High health risks with verified medical diagnoses
  - A VI-SPDAT screening score of 8 or more

NOTE: A head of household for a family that meets the above criteria makes the family eligible for Home Stretch.

If the individual is eligible, please complete a Home Stretch Referral Packet that includes all of the following:

- Completed Fax Cover Sheet
- Completed and Signed Home Stretch Consent to Release of Information (ROI)
- Completed InHOUSE Standard Intake Form
- Home Stretch High Service Need Verification Form and Supporting Documents (if applicable)
- Home Stretch Contact Information Form

Contact HOME STRETCH via fax: 855.658.5466, email: HomeStretch@acgov.org, phone: 510.891.8938

v. 2 Effective 6/27/16
Guide to HUD “Chronic Homelessness” Definition

Individuals that meet the federal Housing and Urban Development Department (HUD) definition of chronic homelessness receive prioritized access to certain services and housing opportunities linked with Home Stretch. According to HUD, chronic homelessness means*:

1) A homeless individual or head of household with a disability that meets the HUD definition of a disability who
   (a) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter;
   AND
   (b) has been homeless and living in one of these places continuously for at least 12 months OR on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living in one of the aforementioned places.

Stays in institutional care facilities for fewer than 90 days will not constitute a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility. Institutional care facilities include jails, substance abuse or mental health treatment facilities, hospitals, or other similar facilities.

A family with an adult head of household (or if there is not adult in the family, a minor head of household) who meets all of the above criteria, including a family whose composition has fluctuated while the head of household has been homeless are also considered chronically homeless.

Documentation of chronic homelessness requires:

1) Documentation of a client’s housing history from one or more parties via third party verification, Homeless Management Information System (HMIS) records, or a client self-certification of homelessness with documentation of attempts to obtain this information that failed. NOTE: Third-party documentation of a single encounter with a homeless service provider on a single day within 1 month is sufficient to consider an individual as homeless and living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter for the entire calendar month unless there is evidence of a break.

2) Documentation of a disability from a professional licensed by the state to diagnose and treat the disability and his or her certification that the disability is expected to be of long-continuing or of indefinite duration and substantially impedes the individual’s ability to live independently OR written verification from the Social Security Administration OR the receipt of a disability check. NOTE: For Home Stretch, documentation from a licensed professional is preferable as this documentation can help qualify individuals for disability specific services and housing opportunities that the other forms of documentation may not provide.

*Please note: This is an updated definition of chronic homelessness issued by HUD effective 1-15-16.
# Home Stretch Document Flow Diagram

<table>
<thead>
<tr>
<th>Outreach and Referral</th>
<th>Home Stretch Staff</th>
<th>Housing Navigation – helping people obtain permanent housing</th>
<th>Housing Match – Housing Locator and PSH Service Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Stretch Referral Documents:</strong></td>
<td><strong>Workflow:</strong></td>
<td><strong>Document Readiness- Required Forms:</strong></td>
<td><strong>Home Stretch Staff:</strong></td>
</tr>
<tr>
<td>• Fax Cover Sheet and Checklist</td>
<td>1. Referral review and feedback</td>
<td>• Housing Profile Form</td>
<td>• Match “document ready” clients to available housing based on criteria and prioritization.</td>
</tr>
<tr>
<td>• Home Stretch/HMIS Release of Information Form</td>
<td>2. Eligibility determined by HMIS Standard Intake</td>
<td>• Government- issued photo ID</td>
<td><strong>Documents Required at Match:</strong></td>
</tr>
<tr>
<td>• HMIS Standard Intake Form</td>
<td>3. Eligible individuals entered into HMIS</td>
<td>• Social Security Card</td>
<td>• Income verification (&lt;60 days)</td>
</tr>
<tr>
<td>• Priority Assessment – VI-SPDAT 2.0 (Family, Single, or TAY) or verification of frequent contact with health/law enforcement or medical diagnostic verification</td>
<td>4. Prioritization of Home Stretch clients and linkage with housing navigators based on priority and capacity</td>
<td>• Vets verification (if applicable)</td>
<td>• Homelessness verification (&lt;60 days)</td>
</tr>
<tr>
<td>• Contact Information Form</td>
<td><strong>Document Readiness- Recommended Forms:</strong></td>
<td>• Disability verification (specific type, if applicable to client) – serious mental illness, HIV/AIDS, developmental disability, substance use disorder</td>
<td>• Program Specific Applications and Forms</td>
</tr>
<tr>
<td></td>
<td>• Income Verification</td>
<td>• Homelessness Verification</td>
<td><strong>Housing Locator:</strong></td>
</tr>
<tr>
<td></td>
<td>• Tenant Resume/Sample Housing Application</td>
<td><strong>Housing Match – Housing Locator and PSH Service Providers:</strong></td>
<td>• Works with landlord to finalize move-in agreements</td>
</tr>
<tr>
<td></td>
<td>• Tenant/Credit History Report</td>
<td>• Housing retention, health, increase assets, positive transitions</td>
<td><strong>PSH Service Providers:</strong></td>
</tr>
<tr>
<td></td>
<td>• Other Documents from Household Members or Special Needs (see Home Stretch Documentation Checklist for further info)</td>
<td></td>
<td>• Housing retention, health, increase assets, positive transitions</td>
</tr>
</tbody>
</table>

**Contact HOME STRETCH via fax: 855.658.5466, email: HomeStretch@acgov.org, phone: 510.891.8938**

v. 2 Effective 6/27/16
Consent for the Release of Confidential Health, HIV/AIDS, Alcohol or Drug, Mental Health, and Housing Information to Alameda County Health Care Services Agency – Home Stretch

Home Stretch is a collaborative project of the Alameda County Health Care Services Agency and the members of its health, HIV/AIDS, alcohol or drug, mental health, and the InHOUSE housing, services, and program network. A list of current programs participating in Home Stretch is available upon request and at the following website: http://everyonehome.org/our-work/home-stretch/

I, ________________________________, authorize 
(Print Name of participant/patient)

Home Stretch participating agencies to communicate with and disclose to one another the following information to help me obtain permanent housing and needed and desired services. Information will only be shared with and used by people associated with the Home Stretch project that need and will use my information to help me obtain services and housing [initial each category that applies]:

_____ Data collected about me and entered into the InHOUSE (HMIS data) system including intake, annual update, exit, program entry/exit, and services data. This data includes my name, age, date of birth, gender, race, ethnicity, marital status, veteran status, education, disability information, employment information, household relationships, living situation, income amount and type, benefits information, health insurance, income amount and type, benefits information, pregnancy status, legal information, programs and services needed and provided, and outcomes of services provided;

_____ Initial and subsequent evaluations of my service needs and health conditions by Home Stretch and its network members;

_____ Summaries of physical health, HIV/AIDS, alcohol/drug and mental health assessment results and service use history for the past 12 months.

_____ Other: ________________________________

The purpose of the disclosures authorized in this consent is to: Enable Home Stretch and its network members to evaluate my need and desire for services, provide and coordinate services to me, determine my eligibility for specific service and housing programs, and to support me in obtaining permanent housing.

Contact HOME STRETCH via fax: 855.658.5466, email: HomeStretch@acgov.org, phone: 510.891.8938
Consent for the Release of Confidential Health, HIV/AIDS, Alcohol or Drug, Mental Health, and Housing Information to Alameda County Health Care Services Agency – Home Stretch

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that records concerning mental health services I receive are protected by state law.

I understand that I may revoke or “take back” this consent at any time. If I “take back” my consent, however, this will only effect future sharing of information. Information shared prior to taking back my consent cannot be changed retroactively. This consent expires automatically 6 months after the date of my last services from a Home Stretch provider. Home Stretch services end after I obtain permanent housing. To revoke this consent, I must request in writing my wish to take back my consent with a designated Home Stretch provider OR with the Alameda County Health Care Services Agency – 1404 Franklin St., STE 200, Oakland CA 94612; homestretch@acgov.org OR by fax to (855) 658-5466. I have the right to receive a copy of all InHOUSE (HMIS) information collected about me and shared between participating agencies. I may also amend and correct InHOUSE (HMIS) information collected about me, which may be incorrect.

I understand the potential for information shared about me under this authorization to be redisclosed or shared again by the recipient and not necessarily protected by this authorization. I understand that the purpose of Home Stretch is the coordination of care and improved access to services and permanent housing resources. I understand that I will not be able to participate in coordinated care if I do not sign this Authorization, but individual service providers and government agencies listed may not deny me services if I refuse to sign this authorization. I have been provided a copy of this form.

________________________________________
Date

________________________________________
Signature of Client

Signature of person signing form if not client

Describe authority to sign on behalf of client:

________________________________________
Agency Representative that helped with this consent form:

________________________________________
Print Agency Representative Name

________________________________________
Agency Name

________________________________________
Signature of Agency Representative

Contact HOME STRETCH via fax: 855.658.5466, email: HomeStretch@acgov.org, phone: 510.891.8938
FAX

TO: EveryOne Home – Home Stretch

FAX: (855) 658-5466

PHONE: (510) 891-8938

FROM:

FAX:

PHONE:

SUBJECT: Referral to Home Stretch

DATE: [Click to select date]

Contact for Questions about Referral

Name: ____________________________________________

Agency/Program: _______________________________________

Phone Number: ______________________________________

E-mail: __________________________________________

Are you the client’s Housing Navigator?  □ Yes  □ No

If not, please list Housing Navigator’s name and contact information (if known):

________________________________________________________________________

Make sure you verify eligibility AND include all of the following with the referral (Complete Checklist):

Client HMIS ID# (if known): ______________________________

☐ Completed and Signed Home Stretch Consent to Release of Information (ROI); AND

☐ Completed InHOUSE Standard Intake Form OR updated data in HMIS for this client; AND

☐ Home Stretch Contact Information Form OR updated contact information in HMIS for this client.

☐ Home Stretch High Service Need Verification Form and Supporting Documents OR updated VI-SPDAT in HMIS (if applicable)

v. 1 Effective 6/27/16
## Home Stretch – Participating Providers

<table>
<thead>
<tr>
<th>Abode Services</th>
<th>Bonita House, Inc.</th>
<th>Homeless Action Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordable Housing Associates</td>
<td>BOSS</td>
<td>Housing Consortium of the East Bay</td>
</tr>
<tr>
<td>Alameda Alliance for Health</td>
<td>Building Futures with Women and Children</td>
<td>LifeLong Medical Care</td>
</tr>
<tr>
<td>Alameda County Housing and Community Development</td>
<td>City of Berkeley Department of Health, Housing, and Community Services</td>
<td>Operation Dignity</td>
</tr>
<tr>
<td>Alameda County Health Care Services Agency</td>
<td>City of Oakland Department of Human Services</td>
<td>Options Recovery Services</td>
</tr>
<tr>
<td>Health Care for the Homeless and Behavioral Health Housing Services Office</td>
<td>Community Health Center Network (CHCN) Federally Qualified Health Centers</td>
<td>Resources for Community Development</td>
</tr>
<tr>
<td>Alameda Health System</td>
<td>Covenant House</td>
<td>Roots Health Center</td>
</tr>
<tr>
<td>Alameda Point Collaborative</td>
<td>Davis Street Family Resource Center</td>
<td>Rubicon Programs</td>
</tr>
<tr>
<td>Anka Behavioral Health, Inc.</td>
<td>East Bay Community Law Center Eviction Prevention Housing Clinic</td>
<td>Second Chance</td>
</tr>
<tr>
<td>Anthem Blue Cross – Alameda County Medi-Cal Plan and Provider Network</td>
<td>East Bay Community Recovery Project</td>
<td>St. Mary’s Center</td>
</tr>
<tr>
<td>Ark of Refuge</td>
<td>East Oakland Community Project</td>
<td>Satellite Affordable Housing Associates</td>
</tr>
<tr>
<td>Bay Area Community Services</td>
<td>Eden Information and Referral (2-1-1)</td>
<td>Sutter Health East Bay – Alta Bates, Summit, and Eden Medical Centers</td>
</tr>
<tr>
<td>Bay Area Legal Aid</td>
<td>EveryOne Home</td>
<td>Swords to Plowshares</td>
</tr>
<tr>
<td>Bay Area Youth Collaborative</td>
<td>FESCO</td>
<td>Tri-City Health Center</td>
</tr>
<tr>
<td>Berkeley Drop-In Center</td>
<td>First Place for Youth</td>
<td>U.S. Department of Veteran Affairs</td>
</tr>
<tr>
<td>Berkeley Food and Housing Project</td>
<td>Fred Finch Youth Center</td>
<td>Volunteers of America</td>
</tr>
<tr>
<td></td>
<td>Goodwill Industries, Inc.</td>
<td>Women’s Day Time Drop-In Center</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Workforce Collaborative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YEAH!</td>
</tr>
</tbody>
</table>

Contact **HOME STRETCH** via fax: 855.658.5466, email: [HomeStretch@acgov.org](mailto:HomeStretch@acgov.org), phone: 510.891.8938

**v. 1 Effective 7/11/16**
### Project Name: __________________________ Start: __________________________ ServicePoint ID: __________________________

**Entry Type:**
- [ ] HUD
- [ ] VA
- [ ] PATH

**First:** __________________________ **Middle:** __________________________ **Suffix:** __________________________

**Alias:** __________________________

**Social Security Number:**
- [ ] Full name reported
- [ ] Partial, Street or Code Name
- [ ] Client doesn’t know
- [ ] Client refused

### Household Information
**What kind of household do you have?**
- [ ] Single adult, no children
- [ ] Female single parent
- [ ] Male single parent
- [ ] Couple with no children
- [ ] Two parent family with children
- [ ] Couple (parent and friend) and children
- [ ] Foster parent(s) and children
- [ ] Grandparent(s) and children
- [ ] Non-custodial caregiver(s)
- [ ] Other: __________________________

**Relationship to Head of Household:**
- [ ] Self (Head of Household)
- [ ] HoH’s child
- [ ] HoH’s spouse or partner
- [ ] HoH’s other relation member
- [ ] Other: non-relation member

**Race**
- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Black or African American
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] White
- [ ] Other: __________________________
- [ ] Client doesn’t know
- [ ] Client refused

### Emergency Shelter
**Emergency Shelter** (including hotel or motel paid for with an emergency shelter voucher)
- [ ] Hotel or motel paid for without emergency shelter voucher
- [ ] Rental by client, no ongoing housing subsidy
- [ ] Residential project or halfway house with no homeless criteria
- [ ] Hospital or other residential non-psychiatric medical facility
- [ ] Psychiatric hospital or other psychiatric facility
- [ ] Jail, prison or juvenile detention facility
- [ ] Staying or living in a FAMILY member’s room, apartment or house
- [ ] Staying or living in a FRIEND’s room, apartment or house
- [ ] Substance abuse treatment facility or detox center
- [ ] Owned by client, no ongoing housing subsidy
- [ ] Owned by client, with ongoing housing subsidy
- [ ] Permanent housing for formerly homeless persons (CoC project; HUD legacy programs; or HOPWA PH, or Rapid Re-housing)
- [ ] Long-term care facility or nursing home
- [ ] Safe Haven (note: none in Alameda Co.)
- [ ] Foster care home or foster care group home
- [ ] Client doesn’t know
- [ ] Client refused

**Residence Prior to Project Entry**
- [ ] More than three months, but less than one year
- [ ] One year or longer
- [ ] Client doesn’t know
- [ ] Client refused

**Length of stay in Residence prior to entry**
- [ ] One day or less
- [ ] Two days to one week
- [ ] More than one week, but less than a month
- [ ] One to three months

**More than one week, but less than a month**
- [ ] More than one week, but less than a month
- [ ] More than three months, but less than one year
- [ ] One year or longer
- [ ] Client doesn’t know
- [ ] Client refused
### InHOUSE Standard Intake Form

#### Housing Status

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Homeless</td>
</tr>
<tr>
<td>2</td>
<td>At imminent risk of losing housing</td>
</tr>
<tr>
<td>3</td>
<td>Homeless only under other federal statutes</td>
</tr>
<tr>
<td>4</td>
<td>Fleeing domestic violence</td>
</tr>
<tr>
<td>5</td>
<td>Stably housed</td>
</tr>
</tbody>
</table>

#### Domestic Violence

- Are you, or have you been a survivor of domestic or intimate partner violence?  
  - No  
  - Client doesn’t know  
  - Yes  
  - Client refused

- **If YES, how long ago did you have this experience?**  
  - Within the past 3 months  
  - One year ago or more  
  - 3 to 6 months ago  
  - 6 months to 1 year ago  
  - Client doesn’t know  
  - Client refused

- **If Yes, are you currently fleeing?**  
  - No  
  - Yes  
  - Client doesn’t know  
  - Client refused

#### Education

- What is the highest level of school that you have completed?  
  - Less than Grade 5  
  - Grades 5-6  
  - Grades 7-8  
  - Grades 9-11  
  - Grade 12  
  - School program does not have grade levels  
  - GED  
  - Some college 
  - Client doesn’t know  
  - Client refused

#### Employment

- Are you presently employed?  
  - No  
  - Yes  
  - Client doesn’t know  
  - Client refused

- **If employed, is this permanent, temporary or seasonal work?**  
  - Full-time  
  - Part-time  
  - Seasonal  
  - Client doesn’t know

#### City/State Info

- **What is the City, State of your last permanent housing where you lived for 90 days or more?**
- **What is the City, State of the high school you last attended? (child: blank)**
- **What is the City, State of your family residence when you were born?**

#### CoC Location

- CA-502

#### In permanent housing

- No  
- Yes (complete Housing Assessment form)

#### Length of Time on Street, or in Emergency Shelter

- **Client entering from the streets, shelter or safe haven?**  
  - No  
  - Client doesn’t know  
  - Yes  
  - Client doesn’t know

- **If Yes, Approximate date started:**

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never in 3 years</td>
<td></td>
</tr>
<tr>
<td>One time</td>
<td></td>
</tr>
<tr>
<td>Two times</td>
<td></td>
</tr>
<tr>
<td>Three times</td>
<td></td>
</tr>
<tr>
<td>One month</td>
<td></td>
</tr>
<tr>
<td>2-12 months</td>
<td></td>
</tr>
<tr>
<td>More than 12 months</td>
<td></td>
</tr>
</tbody>
</table>

- **Number of times homeless (on the streets or in an emergency shelter, or safe haven) in the past three years including today:**

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Never in the 3 years</td>
</tr>
<tr>
<td>1</td>
<td>One time</td>
</tr>
<tr>
<td>2</td>
<td>Two times</td>
</tr>
<tr>
<td>3</td>
<td>Three times</td>
</tr>
<tr>
<td>4</td>
<td>One month (this time is the first month)</td>
</tr>
<tr>
<td>5</td>
<td>2-12 months (___ months)</td>
</tr>
<tr>
<td>6</td>
<td>More than 12 months</td>
</tr>
</tbody>
</table>

- **Total number of months homeless on the street, in emergency shelter, or safe haven in the past three years:**

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Never in the 3 years</td>
</tr>
<tr>
<td>1</td>
<td>One month</td>
</tr>
<tr>
<td>2</td>
<td>Two months</td>
</tr>
<tr>
<td>3</td>
<td>Three months</td>
</tr>
<tr>
<td>4</td>
<td>Four or more times</td>
</tr>
<tr>
<td>5</td>
<td>Client doesn’t know</td>
</tr>
<tr>
<td>6</td>
<td>Client refused</td>
</tr>
</tbody>
</table>

---

**InAlameda County:**

- 1 Alameda  
- 2 Albany  
- 3 Berkeley  
- 4 Castro Valley  
- 5 Dublin  
- 6 Emeryville  
- 7 Fremont  
- 8 Hayward  
- 9 Livermore

**InOther County:**

- 10 Newark  
- 11 Oakland  
- 12 Piedmont  
- 13 Pleasanton  
- 14 San Leandro  
- 15 San Lorenzo  
- 16 Sunol  
- 17 Union City  
- 18 Other unincorporated

---

**InAlameda County:**

- Alameda County
## Income

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earned income (i.e., employment income)</td>
<td>$ __ __ __ . 00</td>
</tr>
<tr>
<td>Unemployment Insurance</td>
<td>$ __ __ __ . 00</td>
</tr>
<tr>
<td>Supplemental Security Income (SSI)</td>
<td>$ __ __ __ . 00</td>
</tr>
<tr>
<td>Social Security Disability Income (SSDI)</td>
<td>$ __ __ __ . 00</td>
</tr>
<tr>
<td>Retirement Income from Social Security</td>
<td>$ __ __ __ . 00</td>
</tr>
<tr>
<td>VA Service-Connected Disability Compensation</td>
<td>$ __ __ __ . 00</td>
</tr>
<tr>
<td>VA Non-Service-Connected Disability Pension</td>
<td>$ __ __ __ . 00</td>
</tr>
<tr>
<td>Worker’s Compensation</td>
<td>$ __ __ __ . 00</td>
</tr>
<tr>
<td>Temporary Assistance for Needy Families (TANF)</td>
<td>$ __ __ __ . 00</td>
</tr>
<tr>
<td>General Assistance (GA)</td>
<td>$ __ __ __ . 00</td>
</tr>
<tr>
<td>Private disability Insurance</td>
<td>$ __ __ __ . 00</td>
</tr>
<tr>
<td>Pension or retirement income from a former job</td>
<td>$ __ __ __ . 00</td>
</tr>
<tr>
<td>Child Support</td>
<td>$ __ __ __ . 00</td>
</tr>
<tr>
<td>Alimony or other spousal support</td>
<td>$ __ __ __ . 00</td>
</tr>
<tr>
<td>Other source: __________________</td>
<td>$ __ __ __ . 00</td>
</tr>
</tbody>
</table>

**Total Monthly Income:** $ __ __ __ . 00

## Non-Cash Benefits

<table>
<thead>
<tr>
<th>Source</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No/None at all</td>
<td>Yes (Identify source below)</td>
</tr>
<tr>
<td>Client doesn’t know</td>
<td>Client refused</td>
</tr>
</tbody>
</table>

## Health Insurance

**Covered by Health Insurance:**

<table>
<thead>
<tr>
<th>Source</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No/None at all</td>
<td>Yes (Identify source below)</td>
</tr>
<tr>
<td>Client doesn’t know</td>
<td>Client refused</td>
</tr>
</tbody>
</table>

## Disability

**Do you have a physical, mental or emotional impairment, a post-traumatic stress disorder, or brain injury; a developmental disability, HIV/AIDS, or a diagnosable substance abuse problem?**

<table>
<thead>
<tr>
<th>Physical</th>
<th>Mental Health</th>
<th>Chronic Health Condition</th>
<th>Alcohol Drugs</th>
<th>Both</th>
<th>Developmental</th>
<th>HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:**

<table>
<thead>
<tr>
<th>Physical</th>
<th>Mental Health</th>
<th>Chronic Health Condition</th>
<th>Alcohol Drugs</th>
<th>Both</th>
<th>Developmental</th>
<th>HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Expected to substantially impair ability to live independently:**

<table>
<thead>
<tr>
<th>Physical</th>
<th>Mental Health</th>
<th>Chronic Health Condition</th>
<th>Alcohol Drugs</th>
<th>Both</th>
<th>Developmental</th>
<th>HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Documentation of the disability and severity on file:**

<table>
<thead>
<tr>
<th>Physical</th>
<th>Mental Health</th>
<th>Chronic Health Condition</th>
<th>Alcohol Drugs</th>
<th>Both</th>
<th>Developmental</th>
<th>HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Currently receiving services/treatment for this disability:**

<table>
<thead>
<tr>
<th>Physical</th>
<th>Mental Health</th>
<th>Chronic Health Condition</th>
<th>Alcohol Drugs</th>
<th>Both</th>
<th>Developmental</th>
<th>HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

**Staff Completing (Printed Name):**

**Date:**
Contact Information

Client Name: _______________________________ Client HMIS ID# (if known): ____________

Client Phone Number (if available): ________________________________

Client Mailing Address (if available): ________________________________

Client Email Address (if available): ________________________________

Alternative Contact Name #1: _________________________________________

Alternative Contact #1 Phone Number (if available): __________________

Alternative Contact #1 Email Address (if available): __________________

Alternative Contact #1 Relationship to Client Description (please note if this person will be acting as the client’s Housing Navigator):

______________________________________________________________

Alternative Contact Name #2: _________________________________________

Alternative Contact #2 Phone Number (if available): __________________

Alternative Contact #2 Email Address (if available): __________________

Alternative Contact #2 Relationship to Client Description

______________________________________________________________