CARES OF NY, INC
ENDING HOMELESSNESS

NY-511 STHC COORDINATED ENTRY PSH/RRH ASSESSMENT

The following information should be collected in a private setting, allowing for confidentiality when responding to each question.

Participants should be informed that the questions are intended to determine appropriate and preferred housing connections.

When all data is collected, please scan, and send via secure/encrypted messaging to:

511CE@caresny.org / fax: 518-489-2237

IF CLIENT IS NOT SEEKING HOUSING SERVICES, THIS ASSESSMENT DOES NOT NEED TO BE COMPLETED

HOUSEHOLD INFORMATION

*INTAKE DATE	*FIRST NAME	*LAST NAME
/ /		

*SOCIAL SECURITY NUMBER

(enter "9" for any missing numbers in an Approximate or Partial SSN)

___ ___ ___ - ___ ___ - ___ ___ ___ ___

*GENDER (Please select all that apply)

❑ Woman (Girl if child) ❑Man (Boy if child) ❑Transgender ❑Questioning
❑ Culturally Specific Identity (e.g. Two-Spirit) ❑Non-binary ❑Different Identity

*BIRTHDATE

______/______/______

*RACE (choose all that apply)

❑American Indian, Alaska Native, or Indigenous
❑Asian or Asian American
❑Black, African American, or African
❑Hispanic/Latina/e/o
❑Middle Eastern or North African
❑Native Hawaiian or Pacific Islander
❑White

Would you like to add any additional information regarding your race/ethnic identity?

APPLICANT PHONE NUMBER:

(____) - __________ - __________

APPLICANT EMAIL ADDRESS:

ALTERNATE CONTACT INFORMATION

NAME: RELATIONSHIP TO APPLICANT:

PHONE NUMBER:

COUNTY OF PREFERRED RESIDENCY

❑Delaware ❑Otsego ❑Broome ❑Chenango ❑Cortland
❑Tioga

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*PRIOR LIVING SITUATION

Based on the client's living situation **the night before project entry**, where they slept last night.

TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)	*LENGTH OF STAY IN PREVIOUS PLACE
❑ **Place not meant for human habitation** (vehicle, abandoned building, bus/train/subway station etc) ❑ **Emergency shelter**, including **hotel or motel** paid for **with emergency shelter voucher** ❑ Safe Haven	❑ 1 night or less ❑ 2 to 6 nights ❑ 1 week or more, but less than 1 month ❑ 1 month or more, but less than 90 days ❑ 90 days or more, but less than 1 year ❑ 1 year or longer
*APPROXIMATE DATE THIS EPISODE OF HOMELESSNESS STARTED:	
_____/_____/_____	
*REGARDLESS OF WHERE THEY STAYED LAST NIGHT NUMBER OF TIMES ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS	*TOTAL NUMBER OF MONTHS HOMELESS ON THE STREETS, IN ES, OR IN SH IN THE PAST THREE YEARS
❑ 1 ❑ 2 ❑ 3 ❑ 4+	❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 ❑ More than 12

*CURRENT LIVING SITUATION

Based on the client's living situation **tonight.**

HOMELESS SITUATIONS:	
TYPE OF RESIDENCE (TONIGHT)	
❑ **Place not meant for human habitation** (vehicle, abandoned building, bus/train/subway station etc) ❑ **Emergency shelter**, including **hotel or motel** paid for **with emergency shelter voucher** ❑ Safe Haven	
Location Details:	**Living Situation Verified by:**

*INCOME & SOURCES / NON-CASH BENEFITS

***INCOME FROM ANY SOURCE**	
❑ No ❑ Yes (SEE BELOW)	
IF YES: CHECK & FILL IN **MONTHLY AMOUNT** FOR ALL THAT APPLY	
❑ Earned Income .... $_______	❑ Unemployment Insurance .... $_______
❑ SSI .... $_______	❑ SSDI .... $_______
❑ VA Service-Connected Disability Compensation .... $_______	❑ VA Non-Service Connected Disability Pension .... $_______
❑ Private Disability Insurance .... $_______	❑ Worker's Compensation .... $_______
❑ TANF .... $_______	❑ General Public Assistance .... $_______
❑ Retirement from SSA .... $_______	❑ Pension or Retirement from former job .... $_______
❑ Child Support .... $_______	❑ Alimony or Other Spousal Support .... $_______
❑ Other .... $_______	
***NON-CASH BENEFITS FROM ANY SOURCE**	
❑ No ❑ Yes	
IF YES: CHECK ALL THAT APPLY	
❑ SNAP (Food Stamps) ❑ Special Supplemental Nutrition Program for Women, Infants and Children ❑ Other Source	
❑ TANF Child Care Services ❑ TANF Transportation Service ❑ Other TANF-funded Services	

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*HEALTH INSURANCE / DISABLING CONDITIONS

***COVERED BY HEALTH INSURANCE**	
❑ No ❑ Yes	
IF YES: CHECK ALL THAT APPLY	
MEDICAID ❑ No ❑ Yes	MEDICARE ❑ No ❑ Yes
State Children's Health Insurance Program ❑ No ❑ Yes	Veteran's Health Administration ❑ No ❑ Yes
Employer provided Health insurance ❑ No ❑ Yes	Health ins. Via COBRA ❑ No ❑ Yes
Private Pay Health Insurance ❑ No ❑ Yes	State Health Ins. Adults ❑ No ❑ Yes
Indian Health Services ❑ No ❑ Yes	Other___________________ ❑ No ❑ Yes
***PHYSICAL DISABILITY**	**IF YES:** EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT)	❑ No ❑ Yes
***DEVELOPMENTAL DISABILITY**	
❑ No ❑ Yes	
***CHRONIC HEALTH CONDITION**	**IF YES:** EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT)	❑ No ❑ Yes
***HIV/AIDS**	
❑ No ❑ Yes	
***MENTAL HEALTH DISORDER**	**IF YES**: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT)	❑ No ❑ Yes
***SUBSTANCE USE DISORDER**	**IF YES**: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes, Alcohol (SEE RIGHT) ❑ Yes, Drug (SEE RIGHT) ❑ Yes, Both (SEE RIGHT	❑ No ❑ Yes

* DV STATUS

*DOMESTIC ABUSE SURVIVOR	
❑ No ❑ Yes (SEE BELOW)	
IF YES: WHEN EXPERIENCE OCCURRED	**IF YES:** ARE YOU CURRENTLY FLEEING?
❑ Within the past 3 months ❑ From 6 to 12 months ago ❑ 3 to 6 months ago ❑ More than a year ago	❑ No ❑ Yes

IF YES: It is advised to offer a connection to your local domestic violence services if they are not already engaged in services.

VETERAN STATUS

*Have you ever served in the United States Military?	
❑No ❑Yes	
IF YES: SELECT BRANCH	❑ Army ❑ Air Force ❑ Navy ❑ Marines ❑Coast Guard ❑Space Force ❑ Other

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Questions below are relevant to: Any Additional Household Members.

FIRST NAME / LAST NAME	GENDER	RELATIONSHIP TO HEAD OF HOUSEHOLD

SOCIAL SECURITY NUMBER	BIRTHDATE
(enter "9" for any missing numbers in an Approximate or Partial SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___	______/______/______

PHYSICAL DISABILITY	**IF YES:** EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT)	❑ No ❑ Yes
DEVELOPMENTAL DISABILITY	
❑ No ❑ Yes	
CHRONIC HEALTH CONDITION	**IF YES:** EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT)	❑ No ❑ Yes
HIV/AIDS	
❑ No ❑ Yes	
MENTAL HEALTH DISORDER	**IF YES**: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT)	❑ No ❑ Yes
SUBSTANCE USE DISORDER	**IF YES**: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes, Alcohol (SEE RIGHT) ❑ Yes, Drug (SEE RIGHT) ❑ Yes, Both (SEE RIGHT	❑ No ❑ Yes

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❑ No ❑ Yes (SEE RIGHT)	❑ No ❑ Yes
DEVELOPMENTAL DISABILITY	
❑ No ❑ Yes	
CHRONIC HEALTH CONDITION	**IF YES:** EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT)	❑ No ❑ Yes
HIV/AIDS	
❑ No ❑ Yes	
MENTAL HEALTH DISORDER	**IF YES**: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT)	❑ No ❑ Yes
SUBSTANCE USE DISORDER	**IF YES**: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes, Alcohol (SEE RIGHT) ❑ Yes, Drug (SEE RIGHT) ❑ Yes, Both (SEE RIGHT	❑ No ❑ Yes

CONSENT TO RELEASE PERSONAL INFORMATION

Signing this consent allows Coordinated Entry-participating programs in the NY-511 STHC Continuum of Care to review information related to your application, and to determine eligibility for housing. Regardless of which housing program you may prefer, all applications may be reviewed by the Coordinated Entry Committee which is comprised of representatives from participating provider agencies in the County. The purpose for this *Coordinated Entry Review* process is to ensure each applicant has information and fair access to the range of housing options in the county:

I acknowledge signing this consent allows my release of personal information related to my housing eligibility to representatives of the NY-511 STHC Coordinated Entry Committee.

The content of information to be released includes: My identifying information, household composition, housing & homelessness history, income & benefit status, veteran status, health information, disabilities (if any), certain judicial system involvement (if any), and accommodations required (if any).

The following items **must be initialed** to be included in the use and/or disclosure of other protected health information:

_____ HIV/AIDS related information and/or records.

_____ Genetic testing information and/or records.

_____ Drug/alcohol diagnosis, treatment, or referral information

I hereby authorize the periodic release of the above information to the organizations identified above as often as necessary to determine eligibility and, if eligible, coordinate placement in housing through NY-511 STHC Coordinated Entry. I understand that the information to be released is confidential and protected from further disclosure. The duration of this consent is one year from the date of my signature, unless I specify a date, event or condition upon which it will expire sooner. I understand that I may revoke this consent at any time by notifying my case manager, in writing, except to the extent that action has been taken in reliance on my consent.

Client signature: ____ **Date:** _________________

Witness signature: ____ **Date:** _________________