Georgia Department of Community Affairs

Collection Point:	Entry
Projects/grants:	HOPWA
Clients who are:	Head of Households & Adults

Step 1: Client Demographics - all fields with an "*" are required.

First Name:*_____ **Last Name**:* _____

Middle Name: _____ **Suffix**: _____ **HoH:*** _____

Name Data Quality:*
- ☐ Full Name Reported
- ☐ Partial, or Street Name
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Social Security Number:* _____
- ☐ Full SSN Reported
- ☐ Approximate or Partial SSN
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Birthdate:* _____
- ☐ Full DOB Reported
- ☐ Approximate or Partial DOB
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Ethnicity:*
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Race:* (Select all that apply)
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Gender:*
- ☐ Male
- ☐ Female
- ☐ Transgender Female to Male
- ☐ Transgender Male to Female
- ☐ Client Doesn't Identify Male, Female, or Transgender
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

If Female, Pregnancy Status:*
- ☐ Yes Due Date: _____
- ☐ No
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Veteran Status:* (18 & over)
- ☐ Yes
- ☐ No
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Relationship to Head of Household:*
- ☐ Self
- ☐ Son
- ☐ Daughter
- ☐ Dependent Child
- ☐ Spouse
- ☐ Foster Child
- ☐ Grandchild
- ☐ Other Family Member
- ☐ Other Non-Family Member

Client Contact Information: (CITY, STATE, ZIP REQUIRED FOR HEAD OF HOUSEHOLD)

Address: _____ City/State/Zip:_____

Email:_____ Home Phone: _____

Step 2: Project Enrollment

Project Start Date:*_____ Case Manager:_____

Housing Move-in Date: _____ (**Only** for Permanent Housing projects, including RRH)

Step 3: Entry Assessments

Disabling Condition:*
- ☐ Yes
- ☐ No
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Client Location (The CoC the client is being served in):*
- ☐ Athens/Clarke County (GA-503)
- ☐ Atlanta (GA-500)
- ☐ August (GA-504)
- ☐ Columbus/Russell County (GA-505)
- ☐ Dekalb County (GA-508)
- ☐ Fulton County (GA-502)
- ☐ Ballance of State (GA-501)
- ☐ Marietta/Cobb (GA-506)
- ☐ Savannah/Chatham County (GA-507)

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Step 4: Living Situation*

Living Situation - Identify the residence just prior to (i.e., the night before) enrollment (ONLY SELECT ONE):

*COMPLETE THESE STEPS FOR **ALL** PROJECT TYPES*

HOMELESS SITUATION

- ☐ Place not meant for habitation
- ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- ☐ Safe Haven
- ☐ Interim Housing

Length of stay in this living situation?:* _____

INSTITUTIONAL SITUATION

- ☐ Foster care home or foster care group home
- ☐ Hospital or other residential non-psychiatric medical facility
- ☐ Jail, Prison or Juvenile Detention Center
- ☐ Long-term care facility or nursing home
- ☐ Psychiatric Hospital or Other Psychiatric Facility
- ☐ Substance Abuse Treatment Facility or Detox Center

Length of stay in this living situation?:* _____

TRANSITIONAL AND PERMANENT HOUSING SITUATION

- ☐ Hotel or motel paid for without emergency shelter
- ☐ Owned by client, no ongoing housing subsidy
- ☐ Owned by client, with ongoing housing subsidy
- ☐ Permanent Housing (other than RRH) for Formerly
- ☐ Rental by client, with no ongoing housing subsidy
- ☐ Rental by client, with VASH housing subsidy
- ☐ Rental by client, with GPD TIP subsidy
- ☐ Rental by client, with other ongoing housing subsidy
- ☐ Residential project or halfway house with no home-
- ☐ Staying or living in a family member's room, apart-
- ☐ Staying or living in a friend's room, apartment or
- ☐ Transitional Housing for Homeless Persons
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Length of stay in this living situation?:* _____

*COMPLETE THESE ADDITIONAL STEPS FOR ALL PROJECT TYPES **EXCEPT HOTEL/MOTEL, OR SHORT - TERM HOUSING***

Proceed to Step 5 at bottom of page

Is this less than 90 days?:*

- ☐ No → **Proceed to next page**
- ☐ Yes → **On the night before did you stay on the**
  - ☐ No → **Proceed to next page**
  - ☐ Yes → **Proceed to Step 5 at bottom of page**

Is this less than 7 days?:*

- ☐ No → **Proceed to next page**
- ☐ Yes

Step 5: History of Homelessness

Approximate date homelessness started (The beginning of *this* continuous period of homelessness): *_____

Total # of *times* the client has been on the streets, in ES, or SH in the past three years including today: *_____

Total # of *months* homeless on the street, in ES, or SH in the past three years: *_____

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Step 6: Health Insurance:*

If client has insurance, please select all sources below:		If client has no insurance, record a reason why, for each source below:	
☐	Private	☐	Applied; Decision Pending
		☐	Applied; Client Not Eligible
		☐	Client Did Not Apply
		☐	Insurance Type N/A for this Client
		☐	Client Doesn't Know
		☐	Client Refused
		☐	Data Not Collected
☐	Private - Employer	☐	Applied; Decision Pending
		☐	Applied; Client Not Eligible
		☐	Client Did Not Apply
		☐	Insurance Type N/A for this Client
		☐	Client Doesn't Know
		☐	Client Refused
		☐	Data Not Collected
☐	Private - Individual	☐	Applied; Decision Pending
		☐	Applied; Client Not Eligible
		☐	Client Did Not Apply
		☐	Insurance Type N/A for this Client
		☐	Client Doesn't Know
		☐	Client Refused
		☐	Data Not Collected
☐	Medicare	☐	Applied; Decision Pending
		☐	Applied; Client Not Eligible
		☐	Client Did Not Apply
		☐	Insurance Type N/A for this Client
		☐	Client Doesn't Know
		☐	Client Refused
		☐	Data Not Collected
☐	Medicaid	☐	Applied; Decision Pending
		☐	Applied; Client Not Eligible
		☐	Client Did Not Apply
		☐	Insurance Type N/A for this Client
		☐	Client Doesn't Know
		☐	Client Refused
		☐	Data Not Collected
☐	State Children's Health Insurance Program S-CHIP	☐	Applied; Decision Pending
		☐	Applied; Client Not Eligible
		☐	Client Did Not Apply
		☐	Insurance Type N/A for this Client
		☐	Client Doesn't Know
		☐	Client Refused
		☐	Data Not Collected

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☐	Military Insurance	☐	Applied; Decision Pending
		☐	Applied; Client Not Eligible
		☐	Client Did Not Apply
		☐	Insurance Type N/A for this Client
		☐	Client Doesn't Know
		☐	Client Refused
		☐	Data Not Collected
☐	State Funded	☐	Applied; Decision Pending
		☐	Applied; Client Not Eligible
		☐	Client Did Not Apply
		☐	Insurance Type N/A for this Client
		☐	Client Doesn't Know
		☐	Client Refused
		☐	Data Not Collected
☐	Combined Children's Health Insurance or Medicaid Program	☐	Applied; Decision Pending
		☐	Applied; Client Not Eligible
		☐	Client Did Not Apply
		☐	Insurance Type N/A for this Client
		☐	Client Doesn't Know
		☐	Client Refused
		☐	Data Not Collected
☐	Indian Health Service (IHS)	☐	Applied; Decision Pending
		☐	Applied; Client Not Eligible
		☐	Client Did Not Apply
		☐	Insurance Type N/A for this Client
		☐	Client Doesn't Know
		☐	Client Refused
		☐	Data Not Collected
☐	Health Insurance Obtained Through COBRA	☐	Applied; Decision Pending
		☐	Applied; Client Not Eligible
		☐	Client Did Not Apply
		☐	Insurance Type N/A for this Client
		☐	Client Doesn't Know
		☐	Client Refused
		☐	Data Not Collected
☐	Other Public: _____	☐	Applied; Decision Pending
		☐	Applied; Client Not Eligible
		☐	Client Did Not Apply
		☐	Insurance Type N/A for this Client
		☐	Client Doesn't Know
		☐	Client Refused
		☐	Data Not Collected
☐	**Client Doesn't Know**		
☐	**Client Refused**		
☐	**Data Not Collected**		

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Step 7: Barriers/Special Needs:* Identify whether a client has each individual barrier or not

Alcohol Abuse*	If "Yes", answer this:	**Expected to be of long–continued and indefinite duration and substantially impairs ability to live independently?:**
☐ Client Doesn't Know ☐ Client Refused ☐ No ☐ Yes ☐ Data Not Collected		☐ No ☐ Yes ☐ Client Refused ☐ Client Doesn't Know ☐ Data Not Collected
Chronic Health Condition*	If "Yes", answer this:	**Expected to be of long–continued and indefinite duration and substantially impairs ability to live independently?:**
☐ Client Doesn't Know ☐ Client Refused ☐ No ☐ Yes ☐ Data Not Collected		☐ No ☐ Yes ☐ Client Refused ☐ Client Doesn't Know ☐ Data Not Collected
Developmental Disability*	If "Yes", answer this:	**Expected to substantially impair ability to live independently?:**
☐ Client Doesn't Know ☐ Client Refused ☐ No ☐ Yes ☐ Data Not Collected		☐ No ☐ Yes ☐ Client Refused ☐ Client Doesn't Know ☐ Data Not Collected
Drug Abuse*	If "Yes", answer this:	**Expected to be of long–continued and indefinite duration and substantially impairs ability to live independently?:**
☐ Client Doesn't Know ☐ Client Refused ☐ No ☐ Yes ☐ Data Not Collected		☐ No ☐ Yes ☐ Client Refused ☐ Client Doesn't Know ☐ Data Not Collected
HIV/AIDS*	If "Yes", answer this:	**Expected to substantially impair ability to live independently?:**
☐ Client Doesn't Know ☐ Client Refused ☐ No ☐ Yes ☐ Data Not Collected		☐ No ☐ Yes ☐ Client Refused ☐ Client Doesn't Know ☐ Data Not Collected
Mental Health*	If "Yes", answer this:	**Expected to be of long–continued and indefinite duration and substantially impairs ability to live independently?:**
☐ Client Doesn't Know ☐ Client Refused ☐ No ☐ Yes ☐ Data Not Collected		☐ No ☐ Yes ☐ Client Refused ☐ Client Doesn't Know ☐ Data Not Collected
Physical Disability*	If "Yes", answer this:	**Expected to be of long–continued and indefinite duration and substantially impairs ability to live independently?:**
☐ Client Doesn't Know ☐ Client Refused ☐ No ☐ Yes ☐ Data Not Collected		☐ No ☐ Yes ☐ Client Refused ☐ Client Doesn't Know ☐ Data Not Collected

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Step 8: Domestic Violence:*

Has the client been a victim of Domestic Violence?:*

- ☐ Yes
- ☐ No
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

If "Yes", please answer the following questions:

When did the experience occur?

- ☐ Within the past three months
- ☐ Three to six months ago (excluding 6 months exactly)
- ☐ Six months to one year ago (excluding 1 year exactly)
- ☐ One year ago or more
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Is the client currently fleeing?:

- ☐ Yes
- ☐ No
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Step 9: Medical Assistance:* (ONLY required for those with HIV/AIDS)

Receiving Public HIV/AIDS Medical Assistance?:	☐ YES ☐ NO ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	IF "NO", SELECT REASON WHY:	☐ Applied; Decision Pending ☐ Applied; Client Not Eligible ☐ Client Did Not Apply ☐ Insurance Type N/A for this Client ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected
Receiving AIDS Drug Assistance Program (ADAP)?:	☐ YES ☐ NO ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	IF "NO", SELECT REASON WHY:	☐ Applied; Decision Pending ☐ Applied; Client Not Eligible ☐ Client Did Not Apply ☐ Insurance Type N/A for this Client ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected

Step 10: T-cell/Viral Measurements:* (ONLY required for those with HIV/AIDS)

T-cell Count Available:*

- ☐ No
- ☐ Yes
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

T-cell Count:* _____

How was the data obtained?

- ☐ Client Report
- ☐ Medical Report
- ☐ Other

Viral Load Available:*

- ☐ Not Available
- ☐ Available
- ☐ Undetectable
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Viral Load:* _____

How was the data obtained?

- ☐ Client Report
- ☐ Medical Report
- ☐ Other

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Step 11: Income and Non-Cash Benefits:*

Income Sources:

- ☐ No Income
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

If client has income, check all that apply below, and record MONTHLY amount:

☐ Earned Income (i.e., employment income)	$* _____	☐ General Assistance	$* _____
☐ Unemployment Insurance	$* _____	☐ Retirement income from Social Security	$* _____
☐ Supplemental Security Income (SSI)	$* _____	☐ Veteran's Pension	$* _____
☐ Social Security Disability Insurance (SSDI)	$* _____	☐ Other Pension	$* _____
☐ Veteran's Disability Payment	$* _____	☐ Child Support	$* _____
☐ Private Disability Insurance	$* _____	☐ Alimony or other spousal support	$* _____
☐ Worker's Compensation	$* _____	☐ Other: _____	$* _____
☐ Temporary Assistance for Needy Families (TANF)	$* _____		

Non-Cash Benefit Sources:

- ☐ No Non-Cash Benefits
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

If client receives non-cash benefits, check all that apply below:

- ☐ Supplemental Nutrition Assistance Program (SNAP) (Food Stamps) $ _____
- ☐ TANF Transportation Services
- ☐ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- ☐ Other TANF-funded Services
- ☐ TANF Child Care Services
- ☐ Other Source (Specify:_____)