

Toledo-Lucas County Continuum of Care Universal Entry/Exit Form

Completed by _____ Date _____

Title _____ Agency _____

Check one Entry/Exit Assessment Interim Assessment

Part I: Client and Household Profile

Client Identifiers and Demographics

LAST NAME	FIRST NAME	M.I.	SUFFIX
SOCIAL SECURITY NUMBER _____ - _____ - _____		DATE OF BIRTH ____ / ____ / _____	
GENDER (Check only one) <i>Transgender is defined as identification with, or presentation as, a gender that is different from the gender at birth.</i> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgendered male to female <input type="checkbox"/> Transgendered female to male <input type="checkbox"/> Other: _____		PRIMARY RACIAL IDENTITY (Check only one) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White	
ETHNICITY <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino		SECONDARY RACIAL IDENTITY (Check only one) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White	
EMERGENCY CONTACT (NAME)		EMERGENCY CONTACT PHONE NUMBER (_____) _____ - _____	

Household Information

IS CLIENT HEAD OF HOUSEHOLD? <input type="checkbox"/> Yes <input type="checkbox"/> No	RELATIONSHIP TO HEAD OF HOUSEHOLD (Check only one) <input type="checkbox"/> Daughter <input type="checkbox"/> Father <input type="checkbox"/> Granddaughter <input type="checkbox"/> Grandfather <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandson <input type="checkbox"/> Husband <input type="checkbox"/> Mother	<input type="checkbox"/> Other non-relative <input type="checkbox"/> Other relative <input type="checkbox"/> Self <input type="checkbox"/> Significant other <input type="checkbox"/> Son <input type="checkbox"/> Step-daughter <input type="checkbox"/> Step-son <input type="checkbox"/> Wife <input type="checkbox"/> Unknown
MARITAL STATUS		
TOTAL HOUSEHOLD SIZE		
Attach additional household member sheets (page 9) as needed.		

Housing Summary

ZIP CODE OF LAST PERMANENT ADDRESS

Last place client lived for 90 or more days, which may be current address. If entering any housing program, this is the ZIP code of last permanent address prior to program entry.

LENGTH OF STAY IN PREVIOUS PLACE (Check only one)

- One week or less
- More than one week, but less than one month
- One to three months
- More than three months, but less than one year
- One year or longer

RESIDENCE (Check only one)

If entering any housing program, this is the residence prior to program entry.

- Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- Foster care home or foster care group home
- Hospital (non-psychiatric)
- Hotel or motel paid for without emergency shelter voucher
- Jail, prison or juvenile detention facility
- Owned by client, no housing subsidy
- Owned by client, with housing subsidy
- Permanent housing for formerly homeless persons (such as SHP, S+C, or SRO Mod rehab)
- Place not meant for habitation inclusive of "non-housing service site (outreach programs only)"
- Psychiatric hospital or other psychiatric facility
- Rental by client, no housing subsidy
- Rental by client, with other (non-VASH) housing subsidy
- Rental by client, with VASH housing subsidy
- Safe haven
- 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
- Transitional housing for homeless persons (including homeless youth)
- Other: _____

HOUSING STATUS (Check only one)

- Literally homeless
Sleeping in a place not meant for human habitation, in an emergency shelter, in a hospital or other institution, in transitional housing, or fleeing domestic violence
- Imminently losing housing
Imminently losing housing, whether permanent or temporary, with no subsequent housing options identified (e.g., imminent eviction from private dwelling, discharge from hospital or other institution, living in condemned or otherwise uninhabitable housing)
- Unstably housed and at-risk of losing housing
Experiencing housing instability, but may have one or more other temporary housing options and lacks the resources or support networks to obtain permanent housing (evidenced by frequent moves, being doubled up, pending eviction, living in a motel/hotel, severely overcrowded housing, being discharged from a hospital or other institution)
- Stably housed
Not homeless or at-risk of becoming homeless based on definitions above

IF HOMELESS, EXTENT OF HOMELESSNESS (Check only one)

- First time homeless
- One or two times in the past
- Chronic: Four times or more in the past three years
- Long term: Two years or more

PRIMARY REASON FOR HOMELESSNESS / THREAT TO HOUSING STABILITY (Check only one)

- Criminal activity
- Domestic violence victim
- Eviction
- Health/safety
- Inappropriate living situation w/family, etc.
- Loss of child care
- Loss of job
- Loss of public assistance
- Loss of transportation
- Medical condition
- Mental health
- Mortgage foreclosure
- No affordable housing
- Release from institution
- Substance abuse
- Substandard housing
- Underemployment/low income
- Utility shutoff

Military Service Summary

VETERAN STATUS? <i>For purposes of this assessment, a veteran is someone who has served on active duty in the Armed Forces of the United States. This does not include inactive military reserves or the National Guard unless the person was called up to active duty.</i> <input type="checkbox"/> Yes (client is a veteran) <input type="checkbox"/> No (client is not a veteran)	BRANCH OF THE MILITARY (Check all that apply) <input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marines <input type="checkbox"/> Other: _____
DURATION OF ACTIVE DUTY IN MONTHS	NAME OF WAR ZONE (Check all that apply) <input type="checkbox"/> Europe <input type="checkbox"/> North Africa <input type="checkbox"/> Vietnam <input type="checkbox"/> Laos and Cambodia <input type="checkbox"/> South China Sea <input type="checkbox"/> China, Burma, India <input type="checkbox"/> Korea <input type="checkbox"/> South Pacific <input type="checkbox"/> Persian Gulf <input type="checkbox"/> Afghanistan <input type="checkbox"/> Other: _____
SERVED IN A WAR ZONE? <input type="checkbox"/> Yes <input type="checkbox"/> No	
RECEIVED HOSTILE OR FRIENDLY FIRE WHILE IN WAR ZONE? <input type="checkbox"/> Yes <input type="checkbox"/> No	
NUMBER OF MONTHS IN WAR ZONE?	
DISCHARGE TYPE (Check only one) <input type="checkbox"/> Bad Conduct <input type="checkbox"/> Dishonorable <input type="checkbox"/> General <input type="checkbox"/> Honorable <input type="checkbox"/> Medical <input type="checkbox"/> Other: _____	MILITARY SERVICE ERA (Check all that apply) <input type="checkbox"/> Post September 11 (9/11/2001-Present) <input type="checkbox"/> Persian Gulf Era (8/1991-9/10/2001) <input type="checkbox"/> Post Vietnam (5/1975-7/1991) <input type="checkbox"/> Vietnam Era (8/1964-4/1975) <input type="checkbox"/> Between Korea & Vietnam (2/1955-7/1964) <input type="checkbox"/> Korean War (6/1950-1/1955) <input type="checkbox"/> Between WWII & Korea (8/1947-5/1950) <input type="checkbox"/> World War II (9/1940-7/1947)

Education Summary

HIGHEST LEVEL OF EDUCATION COMPLETED (Check only one) <input type="checkbox"/> No schooling completed <input type="checkbox"/> Nursery school to Grade 4 <input type="checkbox"/> Grade 5 or 6 <input type="checkbox"/> Grade 7 or 8 <input type="checkbox"/> Grade 9 <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade 12, No diploma <input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> Post-secondary school	RECEIVED ANY VOCATIONAL TRAINING OR APPRENTICESHIP CERTIFICATES? <input type="checkbox"/> Yes <input type="checkbox"/> No	IN SCHOOL OR WORKING ON ANY DEGREE? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Certifications and Degrees Earned		
	Degree or Certification	Institution	Date Conferred
			/ /
		/ /	
		/ /	

Employment Summary

IS CLIENT EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No	HOURS WORKED IN PAST WEEK	IF EMPLOYED, TYPE OF WORK (Check only one) <input type="checkbox"/> Permanent—Full Time <input type="checkbox"/> Permanent—Part Time <input type="checkbox"/> Temporary <input type="checkbox"/> Seasonal <input type="checkbox"/> None
IF UNEMPLOYED: LOOKING FOR WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF EMPLOYED: SEEKING ADDITIONAL EMPLOYMENT OR INCREASED HOURS? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Income and Benefits

LAST 30-DAY INCOME AND SOURCES

If a client has no income in the past thirty days, write "No Financial Resources." Otherwise, list sources of income from the following: Alimony or Other Spousal Support, Child Support, Earned Income, General Assistance/Lucas County Jobs and Family Services, Pension From a Former Job, Private Disability Insurance, Retirement Income From Social Security, SSDI, SSI, TANF, Unemployment Insurance, Veteran's Pension, Veteran's Disability, Worker's Compensation, or Other (Specify below)

Source of Income	Amount received in past 30 days	Date first received	Date ended
X. TOTAL INCOME RECEIVED IN PAST 30 DAYS:			

LAST 30-DAY NON-CASH BENEFITS

If a client has no non-cash benefits received in the past thirty days, write "No Non-Cash Benefits." Otherwise, list sources of non-cash benefits from the following: Supplemental Nutrition Assistance Program (Food Stamps), Medicaid, Medicare, SCHIP, Special Supplemental Nutrition Program for WIC, Veteran's Administration (VA) Medical Services, TANF Child Care Services, TANF Transportation Services, Other TANF-Funded Services, Section 8 Public Housing or rental assistance, or Other (Specify below)

Source of Non-cash Benefit	Amount received in past 30 days	Date first received	Date ended
TOTAL NON-CASH BENEFITS RECEIVED IN PAST 30 DAYS:			

Part II: Confidential Dimensions

Data in this section will be entered in a separate assessment on ServicePoint. This information will be used for aggregate reports and will not be accessible to other agencies.

The provided definitions for questions in the Disability/Medical Summary are from the HUD-issued HMIS Data Standards March 2010 Revised Draft Notice.

Special Documentation Requirements

If the response to Chronic Health Condition, Physical Disability, Developmental Disability, or Mental Health Condition is “Yes,” the case manager records must document the condition. Documentation includes written verification from a state-licensed professional, such as a medical service provider or a health-care provider, the Social Security Administration, or the receipt of a disability check (i.e., SSDI check or VA disability benefit check).

Definitions

Disabling Condition – One or more of: (1) a disability as defined in Section 223 of the Social Security Act; (2) a physical, mental, or emotional impairment which is (a) expected to be of long-continued and indefinite duration, (b) substantially impedes an individual’s ability to live independently, and (c) of such a nature that such ability could be improved by more suitable housing conditions; (3) a developmental disability as defined in Section 102 of the Developmental Disabilities Assistance and Bill of Rights Act; (4) the disease of acquired immunodeficiency syndrome or any conditions arising from the etiological agency for acquired immunodeficiency syndrome; or (5) a diagnosable substance abuse disorder.

Chronic Health Condition – A diagnosed condition that is more than three months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples of chronic health conditions include, but are not limited to, heart disease (including coronary heart disease, angina, heart attack and any other kind of heart condition or disease); severe asthma; diabetes; arthritis-related conditions (including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia); adult onset cognitive impairments (including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive related conditions); severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.

Physical Disability – A physical impairment which is (a) expected to be of long, continued and indefinite duration, (b) substantially impedes an individual’s ability to live independently, and (c) of such a nature that such ability could be improved by more suitable housing conditions.

Developmental Disability – A severe, chronic disability that is attributed to a mental or physical impairment (or combination of physical and mental impairments) that occurs before 22 years of age and limits the capacity for independent living and economic self-sufficiency.

Mental Health Condition – May include serious depression, serious anxiety, hallucinations, violent behavior or thoughts of suicide.

HIV/AIDS – Refers to either (a) a medical diagnosis of acquired immune deficiency syndrome (AIDS) or (b) a positive test for human immunodeficiency virus (HIV).

Disability/Medical Summary (Confidential Dimensions)

<p>GENERAL HEALTH COMPARED TO OTHERS YOUR AGE? (Check only one)</p> <p><input type="checkbox"/> Excellent</p> <p><input type="checkbox"/> Very Good</p> <p><input type="checkbox"/> Good</p> <p><input type="checkbox"/> Fair</p> <p><input type="checkbox"/> Poor</p>	<p>DO YOU HAVE A DISABLING CONDITION?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>PREGNANT</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>IF PREGNANT, DUE DATE?</p> <p>___ ___ / ___ ___ / ___ ___ ___</p>
<p>DO YOU HAVE A CHRONIC HEALTH CONDITION?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>[ENTRY ONLY] IF YES, ARE YOU CURRENTLY RECEIVING SERVICES OR TREATMENT FOR THIS YOUR CHRONIC HEALTH CONDITION?</p> <p>[EXIT AND ANNUAL ASSESSMENT ONLY] IF YES, DID YOU RECEIVE SERVICES OR TREATMENT FOR YOUR CHRONIC HEALTH CONDITION WHILE IN THE PROGRAM?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>DO YOU HAVE A PHYSICAL DISABILITY?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>[ENTRY ONLY] IF YES, ARE YOU CURRENTLY RECEIVING SERVICES OR TREATMENT FOR YOUR PHYSICAL DISABILITY?</p> <p>[EXIT AND ANNUAL ASSESSMENT ONLY] IF YES, DID YOU RECEIVE SERVICES OR TREATMENT FOR YOUR PHYSICAL DISABILITY WHILE IN THE PROGRAM?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>DO YOU HAVE A DEVELOPMENTAL DISABILITY?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>[ENTRY ONLY] IF YES, ARE YOU CURRENTLY RECEIVING SERVICES OR TREATMENT FOR THIS DEVELOPMENTAL DISABILITY?</p> <p>[EXIT AND ANNUAL ASSESSMENT ONLY] IF YES, DID YOU RECEIVE SERVICES OR TREATMENT FOR YOUR DEVELOPMENTAL DISABILITY WHILE IN THE PROGRAM?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>DO YOU HAVE A MENTAL HEALTH CONDITION?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>[ENTRY ONLY] IF YES, ARE YOU CURRENTLY RECEIVING SERVICES OR TREATMENT FOR YOUR MENTAL HEALTH CONDITION?</p> <p>[EXIT AND ANNUAL ASSESSMENT ONLY] IF YES, DID YOU RECEIVE SERVICES OR TREATMENT FOR YOUR MENTAL HEALTH CONDITION WHILE IN THE PROGRAM?</p>
<p>IF YES, IS YOUR MENTAL HEALTH CONDITION EXPECTED TO BE OF LONG-CONTINUED AND INDEFINITE DURATION, AND SUBSTANTIALLY IMPAIR YOUR ABILITY TO LIVE INDEPENDENTLY?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>DO YOU HAVE HIV/AIDS?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>[ENTRY ONLY] IF YES, ARE YOU CURRENTLY RECEIVING SERVICES OR TREATMENT FOR HIV/AIDS?</p> <p>[EXIT AND ANNUAL ASSESSMENT ONLY] IF YES, DID YOU RECEIVE SERVICES OR TREATMENT WHILE IN THE PROGRAM?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>

Substance Abuse (Confidential Dimensions)

SUBSTANCE ABUSE PROBLEM (Check only one) <input type="checkbox"/> No <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Drug abuse <input type="checkbox"/> Both alcohol and drug abuse	IF YES, EXPECTED TO BE LONG-CONTINUED AND INDEFINITE DURATION AND SUBSTANTIALLY IMPAIR ABILITY TO LIVE INDEPENDENTLY? <input type="checkbox"/> Yes <input type="checkbox"/> No
	[ENTRY ONLY] IF YES, ARE YOU CURRENTLY RECEIVING SERVICES OR TREATMENT FOR SUBSTANCE ABUSE? <input type="checkbox"/> Yes <input type="checkbox"/> No
	[EXIT AND ANNUAL ASSESSMENT ONLY] IF YES, DID YOU RECEIVE SERVICES OR TREATMENT WHILE IN THE PROGRAM? <input type="checkbox"/> Yes <input type="checkbox"/> No

Domestic Violence (Confidential Dimensions)

DOMESTIC VIOLENCE SURVIVOR? <input type="checkbox"/> Yes <input type="checkbox"/> No	WHEN MOST RECENT DOMESTIC VIOLENCE EXPERIENCE OCCURRED (Check only one) <input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago <input type="checkbox"/> Six to twelve months ago <input type="checkbox"/> More than a year ago
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Part III: Additional Household Member(s)

Identifiers and Demographics

LAST NAME		FIRST NAME		M.I.	SUFFIX
SOCIAL SECURITY NUMBER _____ - _____ - _____			DATE OF BIRTH ____ / ____ / _____		
GENDER (Check only one) <i>Transgender is defined as identification with, or presentation as, a gender that is different from the gender at birth.</i> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgendered male to female <input type="checkbox"/> Transgendered female to male <input type="checkbox"/> Other: _____			PRIMARY RACIAL IDENTITY (Check only one) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White		
ETHNICITY <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino			SECONDARY RACIAL IDENTITY (Check only one) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White		
RELATIONSHIP TO HEAD OF HOUSEHOLD (Check only one) <input type="checkbox"/> Daughter <input type="checkbox"/> Grandson <input type="checkbox"/> Other relative <input type="checkbox"/> Step-daughter <input type="checkbox"/> Father <input type="checkbox"/> Husband <input type="checkbox"/> Self <input type="checkbox"/> Step-son <input type="checkbox"/> Granddaughter <input type="checkbox"/> Mother <input type="checkbox"/> Significant other <input type="checkbox"/> Wife <input type="checkbox"/> Grandfather <input type="checkbox"/> Other non-relative <input type="checkbox"/> Son <input type="checkbox"/> Unknown <input type="checkbox"/> Grandmother					

Children's School Enrollment (household members aged 5 to 17 only)

IF AGED 5 TO 17 YEARS OLD, ENROLLED IN SCHOOL? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF NOT ENROLLED, DATE LAST ENROLLED IN SCHOOL ____ / ____ / _____	
IF ENROLLED IN SCHOOL, NAME OF SCHOOL		IF NOT ENROLLED, PROBLEMS IN GETTING CHILD ENROLLED (Check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Residency requirements <input type="checkbox"/> Availability of school records <input type="checkbox"/> Birth certificates <input type="checkbox"/> Legal guardianship requirements <input type="checkbox"/> Transportation <input type="checkbox"/> Lack of available preschool programs <input type="checkbox"/> Immunization requirements <input type="checkbox"/> Physical examination records	
TYPE OF SCHOOL <input type="checkbox"/> Public school <input type="checkbox"/> Parochial or other private school			
IF ENROLLED IN SCHOOL, CONNECTED WITH MCKINNEY-VENTO HOMELESS ASSISTANCE SCHOOL LIAISON? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Part IV: Program Entry



Did you collect/provide a response for:

- ZIP code of last permanent address?
- Length of stay in previous address?
- Prior residence?
- Housing status?
- Extent of homelessness (if applicable)?
- Primary reason for homelessness?

This information will be required by ServicePoint for creating a new program entry record. Be sure to also specify the appropriate "Entry Type," such as HUD-40118, HPRP, etc.

Additional Program Entry Details

PROGRAM NAME	DATE OF PROGRAM ENTRY/ENROLLMENT ____ / ____ / _____
AGENCY NAME	
PROGRAM ENTRY NOTES	

Part V: Program Exit

X. DATE OF PROGRAM EXIT/DISCHARGE

___ / ___ / ___

X. DESTINATION TYPE (Check only one)

- Deceased
- Emergency shelter, including hotel or motel paid for with emergency shelter voucher*
- Foster care home or foster care group home
- Hospital (non-psychiatric)
- Hotel or motel paid for without emergency shelter voucher
- Jail, prison or juvenile detention facility
- Owned by client, no ongoing housing subsidy
- Owned by client, with housing subsidy:
- Permanent supportive housing for formerly homeless persons (such as SHP, S+C, or SRO Mod Rehab)
- Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
- Psychiatric hospital or other psychiatric facility
- Rental by client, no ongoing housing subsidy
- Rental by client, VASH Subsidy
- Rental by client, other (non-VASH) housing subsidy
- Safe Haven
- Substance abuse treatment facility or detox center
- Staying or living with family, permanent tenure
- Staying or living with family, temporary tenure (e.g., room, apartment or house)
- Staying or living with friends, temporary tenure (e.g., room, apartment or house)
- Staying or living with friends, permanent tenure
- Transitional housing for homeless persons (including homeless youth)*
- Other: _____

X. REASON FOR LEAVING (Check only one)

- Completed program
- Criminal activity/destruction of property/violence
- Death
- Disagreement with rules/persons
- Left for a housing opportunity before completing program
- Needs could not be met by program
- Non-payment of rent/occupancy charge
- Non-compliance with program
- Reached maximum time allowed by program
- Unknown/disappeared



Be sure to update in your case records and in HMIS:

- Housing status (if applicable)
- Current address
- Phone number
- Income & benefits
- Services received for any disabilities or medical conditions

PROGRAM EXIT NOTES

*Destinations marked with an asterisk are not permissible destinations for HOPWA-funded programs that provide short-term payments to prevent homelessness.