

Information may be collected over time, as it may not be appropriate to go into detail at initial intake. This is **NOT** a client intake form, but rather a data entry tool.

ServicePoint Client Data Entry Form – Client Profile

First Name: _____ **M.I.** _____ **Last Name:** _____

Social Security: _____ - _____ - _____ **Social Security # Data Quality** Full Partial Don't Know/Have Refused

Client ID _____ **Back Date Mode** Yes No **Assessment Date:** _____

DOB _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Unknown
Primary:	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American
Race:	<input type="checkbox"/> Native Hawaiian/ Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Other Multi-Racial
Secondary:	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American
Race:	<input type="checkbox"/> Native Hawaiian/ Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Other Multi-Racial
Ethnicity:	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Other

Is Client Homeless?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does Client have a disability of long duration?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
Is Client Chronically Homeless (see below*)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Homeless Verification:	<input type="checkbox"/> Signed client statement with confirmation statement <input type="checkbox"/> Formal eviction documentation
<input type="checkbox"/> Verification from an institution <input type="checkbox"/> Verification from outreach worker (for on the street)	<input type="checkbox"/> Verification from referring agency/shelter

Living Situation (prior to Entry):		
<input type="checkbox"/> Don't Know	<input type="checkbox"/> Rental House/Apartment.	<input type="checkbox"/> Living with Family
<input type="checkbox"/> Foster Care/Group Home	<input type="checkbox"/> Jail, Prison or Juvenile Facility	<input type="checkbox"/> Living with Friends
<input type="checkbox"/> Perm. housing for Formerly Homeless	<input type="checkbox"/> Domestic Violence Situation	<input type="checkbox"/> Place Not Meant for Habitation
<input type="checkbox"/> Refused	<input type="checkbox"/> Hospital	<input type="checkbox"/> Psychiatric Hospital or Facility
<input type="checkbox"/> Own House/Apartment	<input type="checkbox"/> Emergency Shelter	<input type="checkbox"/> Substance Abuse Treatment Center
<input type="checkbox"/> Transitional Housing for Homeless	<input type="checkbox"/> Hotel/Motel w/o ES Funds	<input type="checkbox"/> Other _____
Length of Stay (prior to Entry):		
<input type="checkbox"/> 1 week or less	<input type="checkbox"/> More than 1 week, but less than 1 month	<input type="checkbox"/> 1 to 3 months
<input type="checkbox"/> More than 3 months, but less than 1 year	<input type="checkbox"/> 1 year or longer	
Extent of homelessness (prior to Entry):		
<input type="checkbox"/> First Time Homeless (Episodic)	<input type="checkbox"/> More than 1 time in the past (Episodic)	
<input type="checkbox"/> Chronic: 4 times in past 3 years	<input type="checkbox"/> Chronic: Long term - 1 year or more	
Zip Code of Last Permanent Address _____		<input type="checkbox"/> Full Zip Code <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
Check if applicable: <input type="checkbox"/> Military Veteran <input type="checkbox"/> Domestic Violence Victim/When Occurred _____		

Income Sources at entry (Check all that apply): Total Monthly Income \$ _____			
<input type="checkbox"/> Alimony	\$ _____	<input type="checkbox"/> Pension/ Retirement	\$ _____
<input type="checkbox"/> Annuities	\$ _____	<input type="checkbox"/> Public Assistance	\$ _____
<input type="checkbox"/> Child Support	\$ _____	<input type="checkbox"/> Railroad Retirement	\$ _____
<input type="checkbox"/> Contributions from others	\$ _____	<input type="checkbox"/> Rental Income	\$ _____
<input type="checkbox"/> Dividends (investments)	\$ _____	<input type="checkbox"/> Retirement Disability	\$ _____
<input type="checkbox"/> Earned Income	\$ _____	<input type="checkbox"/> Section 8/ Public housing	\$ _____
<input type="checkbox"/> Food Stamps	\$ _____	<input type="checkbox"/> Self Employment	\$ _____
<input type="checkbox"/> Interest (Banks)	\$ _____	<input type="checkbox"/> Social Security	\$ _____
<input type="checkbox"/> Medicaid	\$ _____	<input type="checkbox"/> SSDI	\$ _____
<input type="checkbox"/> Medicare	\$ _____	<input type="checkbox"/> SSI	\$ _____
<input type="checkbox"/> State Disability	\$ _____	<input type="checkbox"/> TANF	\$ _____
<input type="checkbox"/> Unemployment Benefits	\$ _____	<input type="checkbox"/> VA Benefits	\$ _____
<input type="checkbox"/> Workers Compensation	\$ _____	<input type="checkbox"/> Other _____	\$ _____
<input type="checkbox"/> Other _____	\$ _____	<input type="checkbox"/> Other _____	\$ _____
<input type="checkbox"/> Other _____	\$ _____	<input type="checkbox"/> Other _____	\$ _____
<input type="checkbox"/> Other _____	\$ _____	<input type="checkbox"/> Other _____	\$ _____

Disability Type: Identify if Long Term(Yes/No) and start date of disability		
<input type="checkbox"/> Alcohol Abuse (Y/N) _____	<input type="checkbox"/> Mental Illness (Y/N) _____	<input type="checkbox"/> Vision Impaired (Y/N) _____
<input type="checkbox"/> Development (Y/N) _____	<input type="checkbox"/> Physical/Mobility Limits (Y/N) _____	<input type="checkbox"/> Dual Diagnosis Other (Y/N) _____
<input type="checkbox"/> Drug Abuse (Y/N) _____	<input type="checkbox"/> HIV/AIDS (Y/N) _____	<input type="checkbox"/> Physical/Medical (Y/N) _____
<input type="checkbox"/> Hearing Impaired (Y/N) _____		
Note: Unless the information is needed for eligibility determination, Disability Information should be collected only after the client has been admitted into the program.		

Household (skip for Singles):		
<input type="checkbox"/> Couple w/no children	<input type="checkbox"/> Non Custodial Caregiver(s)	<input type="checkbox"/> Single w. dependent children
<input type="checkbox"/> Two Parent Family	<input type="checkbox"/> Grandparent(s) and child	<input type="checkbox"/> Couple w. dependent children
<input type="checkbox"/> Female Single Parent	<input type="checkbox"/> Couple (Parent & Friend) and child	<input type="checkbox"/> Caregiver
<input type="checkbox"/> Male Single Parent	<input type="checkbox"/> Single	<input type="checkbox"/> Child under 18
<input type="checkbox"/> Foster Parent(s)	<input type="checkbox"/> Couple	<input type="checkbox"/> Other
Head of House <input type="checkbox"/> Yes <input type="checkbox"/> No Relationship _____	Date Entered/Removed _____	

***Definition of Chronic Homelessness (HUD):** An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years. The individual must have been on the streets or in an emergency shelter (not transitional housing) during these episodes.

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ServicePoint Client Data Entry Form – Basic Household ENTRY

Family/Household Members

Note: in addition to the demographic information below all adult Family/Household members must have a complete Client Profile entered into ServicePoint. Minor household members only need the information below entered into ServicePoint.

First Name: _____		M.I. _____		Last Name: _____	
Social Security: _____ - _____ - _____		DOB _____		Client ID _____	
Head of House <input type="checkbox"/> Yes <input type="checkbox"/> No		Relationship _____		Date Entered/Removed _____	
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Transgender	<input type="checkbox"/> Unknown	
Primary Race:	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	
Race:	<input type="checkbox"/> Native Hawaiian/ Pacific Islander	<input type="checkbox"/> Other	<input type="checkbox"/> Other Multi-Racial		
Secondary Race:	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	
Race:	<input type="checkbox"/> Native Hawaiian/ Pacific Islander	<input type="checkbox"/> Other	<input type="checkbox"/> Other Multi-Racial		
Ethnicity:	<input type="checkbox"/> Hispanic or Latino		<input type="checkbox"/> Other		

First Name: _____		M.I. _____		Last Name: _____	
Social Security: _____ - _____ - _____		DOB _____		Client ID _____	
Head of House <input type="checkbox"/> Yes <input type="checkbox"/> No		Relationship _____		Date Entered/Removed _____	
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Transgender	<input type="checkbox"/> Unknown	
Primary Race:	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	
Race:	<input type="checkbox"/> Native Hawaiian/ Pacific Islander	<input type="checkbox"/> Other	<input type="checkbox"/> Other Multi-Racial		
Secondary Race:	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	
Race:	<input type="checkbox"/> Native Hawaiian/ Pacific Islander	<input type="checkbox"/> Other	<input type="checkbox"/> Other Multi-Racial		
Ethnicity:	<input type="checkbox"/> Hispanic or Latino		<input type="checkbox"/> Other		

First Name: _____		M.I. _____		Last Name: _____	
Social Security: _____ - _____ - _____		DOB _____		Client ID _____	
Head of House <input type="checkbox"/> Yes <input type="checkbox"/> No		Relationship _____		Date Entered/Removed _____	
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Transgender	<input type="checkbox"/> Unknown	
Primary Race:	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	
Race:	<input type="checkbox"/> Native Hawaiian/ Pacific Islander	<input type="checkbox"/> Other	<input type="checkbox"/> Other Multi-Racial		
Secondary Race:	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	
Race:	<input type="checkbox"/> Native Hawaiian/ Pacific Islander	<input type="checkbox"/> Other	<input type="checkbox"/> Other Multi-Racial		
Ethnicity:	<input type="checkbox"/> Hispanic or Latino		<input type="checkbox"/> Other		

First Name: _____		M.I. _____		Last Name: _____	
Social Security: _____ - _____ - _____		DOB _____		Client ID _____	
Head of House <input type="checkbox"/> Yes <input type="checkbox"/> No		Relationship _____		Date Entered/Removed _____	
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Transgender	<input type="checkbox"/> Unknown	
Primary Race:	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	
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Ethnicity:	<input type="checkbox"/> Hispanic or Latino		<input type="checkbox"/> Other		

