Agency's LOGO

SubCook Initial Intake Assessment

Head of Household / All Adult HH Members

HMIS CLIENT ID# | **PROJECT NAME**

Fill-in after ServicePoint Entry

Entry Date (Project Start) | **Date of Engagement** (ES/SO) | **Housing Move-in Date** (PH, PSH, RRH)

Month / Day / Year | *Month / Day / Year* | *Month / Day / Year*

NAME OF HEAD OF HOUSEHOLD (first, middle, last name, suffix (e.g., Jr, Sr, III))

				Client doesn't know	Client refused
First Name		Middle Name		☐	☐
Last Name		Alias/Suffix		☐	☐
SSN			Approx. or Partial SSN Reported ☐	☐	☐
Veteran Status	☐ Yes ☐ No	*Veteran Status is on the Client Profile Tab and may need to be updated if the client is already in ServicePoint.*		☐	☐
Relationship (to HoH)	☐ **SELF (Head of Household)** ☐ HoH's Child ☐ HoH's Spouse/Partner ☐ HoH's Other Relation ☐ Other: Non-Relation		***Use a separate Initial Intake Assessment or HH Member Supplemental page for each additional HH member.***		
Date of Birth			Approx. or Partial DOB Reported ☐	☐	☐
Gender	☐ Male ☐ Female ☐ Trans Female: M to F ☐ Trans Male: F to M		☐ Gender Non-Confirming (i.e. not exclusively M or F)	☐	☐

The above question must be asked with the listed responses, as they are defined by the HMIS Data Standards. The questions below allow the client to better define how they identify or express their gender, as well as their sexual orientation.

What are the client's pronouns? (This is what the client wants people to call them, in addition to their name, like "he," "she," "they," "zi," or something else.) _____

How does the client identify their gender?

☐ Woman/girl ☐ Man/boy ☐ Genderqueer/non-binary/gender non-conforming/gender fluid/agender/Two-Spirit/gender expansive

☐ Questioning my gender identity ☐ Other: _____ ☐ Client doesn't know ☐ Client Refused

Does the client also identify as transgender? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused

How does the client identify their sexual orientation?

☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual

☐ Questioning/Unsure ☐ Other: _____ ☐ Client Doesn't know ☐ Client Refused

				Client doesn't know	Client refused
Ethnicity	☐ Non-Hispanic/Latino	☐ Hispanic/Latino		☐	☐
Primary Race	☐ American Indian or Alaskan Native ☐ Asian	☐ Black/African American ☐ White	☐ Native Hawaiian or Other Pacific Islander	☐	☐
Secondary Race (Leave Blank if None)	☐ American Indian or Alaskan Native ☐ Asian	☐ Black/African American ☐ White	☐ Native Hawaiian or Other Pacific Islander	NA	NA

The above questions must be asked with the listed responses, as they are defined by the HMIS Data Standards. The question below allows the client to better define how they identify or express their ethnicity, race, or nationality, using terms that may not be addressed by the standard responses.			
How does the client identify their ethnicity, race, or nationality? _____			
Primary Language	☐ English	☐ Spanish	☐ Other, specify: _____

Domestic Violence Victim/Survivor	☐ Yes ☐ No	☐	☐
	(If Yes) how long ago was the last incident? ☐ Within the past 3 months ☐ 3-6 months ago ☐ 6-12 months ago ☐ More than a year ago ☐ Client Doesn't Know ☐ Client Refused **(If Yes) are you currently fleeing?** ☐ Yes ☐ No ☐ Client Does Not Know ☐ Client Refused		

DISABILITY ASSESSMENT

Does the client have a disabling condition expected to be of long duration and impedes ability to live independently? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused

Disability Type	(If Yes) Start Date	Will the Condition be long term?	Disability Determination	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?
Alcohol Abuse ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	Notes:			
Alcohol and Drug Abuse ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	Notes:			
Chronic Health Condition ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	Notes:			
Developmental Disability ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	Notes:			
Drug Abuse ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	Notes:			
HIV/AIDS ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	Notes:			
Mental Health Problem ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	Notes:			
Physical Disability ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	Notes:			

Continue to Chronic Homeless Assessment

Chronic Homeless Assessment

RESIDENCE PRIOR TO PROJECT ENTRY: *Where was the client sleeping last night? Or, in other words, what was the client's living situation just prior to entering this project? For non-residential programs (like HP) this is their current situation.*
Choose from Literally Homeless Situation OR Institutional Setting OR Temporary/PSH Situation. Once chosen, stay in that column.

1A. Homeless Situation

☐ Place not meant for human habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
☐ Emergency Shelter (including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter)
☐ Safe Haven

↓ ***Next Answer 2A: Length of Stay.*** ↓

1B. Institutional Situation

☐ Foster care home or foster care group home
☐ Hospital or other residential non-psychiatric medical facility
☐ Jail, prison, or juvenile detention facility
☐ Long term care facility or nursing home
☐ Psychiatric hospital or other psychiatric facility
☐ Substance Abuse Treatment Facility or detox center

↓ ***Next Answer 2B: Length of Stay.*** ↓

1C. Temporary or Permanent Housing Situation

☐ Host Home (non-crisis)
☐ Hotel or motel paid for without ES voucher
☐ Owned by client, NO ongoing housing subsidy
☐ Owned by client, with ongoing housing subsidy
☐ PH (other than RRH) for formerly homeless persons
☐ Rental by client, NO ongoing housing subsidy
☐ Rental by client, with RRH or equivalent subsidy
☐ Rental by client, with VASH housing subsidy
☐ Rental by client with GPD TIP subsidy
☐ Rental by client, other ongoing housing subsidy
☐ Rental by client, with an HCV (tenant or project)
☐ Rental by client in a public housing unit
☐ Residential/halfway house, NO homeless criteria
☐ Staying or living with a family member
☐ Staying or living with a friend
☐ Transitional Housing for homeless persons (including homeless youth)

↓ ***Next Answer 2C: Length of Stay.*** ↓

2A: LENGTH OF STAY: *How long was the client in a Homeless Situation?*

☐ One Day or Less
☐ Two Days to One Week
☐ > One Week but < One Month
☐ One to Three Months
☐ > three months, but < 1 year
☐ One Year or Longer
☐ Client Does Not Know
☐ Client Refused

↓ ***Next Answer 3: Chronic Questions*** ↓

2B: LENGTH OF STAY: *How long was the client in an Institutional Situation?*

☐ One Day or Less🏳
☐ Two Days to One Week🏳
☐ > One Week but < One Month🏳
☐ One to Three Months🏳
(3 months or less)
☐ > three months, but < 1 year
☐ One Year or Longer
☐ Client Does Not Know
☐ Client Refused

🏳*If the client reported Three Months or less, then answer the question below. If the client reports more than 3 months, the client is not chronic, skip the rest of this page.*

On the night before the Institutional Situation, did the client stay on the streets, in ES or SH?
☐ Yes (*proceed below to 3: Chronic Questions*)
☐ No (*the client is NOT Chronic, skip the rest of this page*)

2C: LENGTH OF STAY: *How long was the client in a Housing Situation?*

☐ One Day or Less🏳
☐ Two Days to One Week🏳
(1 week or less)
☐ > One Week but < One Month
☐ One to Three Months
☐ > three months, but < 1 year
☐ One Year or Longer
☐ Client Does Not Know
☐ Client Refused

***If Client is entering ES, SH, or SO**, then answer the question below OR…*
🏳*If the client reported One Week or less, then answer the question below.*
*If the client reports 7 days or more **AND is NOT entering ES, SH, or SO**, then the client is not chronic, skip the rest of this page.*

On the night before the TH/PH Housing Situation, did the client stay on the streets, in ES or SH?
☐ Yes (*proceed below to 3: Chronic Questions*)
☐ No (*the client is NOT Chronic, skip the rest of this page*)

3: CHRONIC QUESTIONS: *(depending on your answer in the above questions).*

3.1: When did the client first become homeless? *Have the client look back to when they first became homeless (not this episode, but the very first time) and enter that approximate date.*	M/D/Y
3.2: Approximate Date this current episode of homelessness began? *Have the client look back to the date of the last time the client had a place to sleep for more than 7 days that was not on the streets in ES or SH.*	M/D/Y
3.3: Regardless of where they stayed last night -- Number of times (episodes) the client has been homeless on the streets, in ES, or SH in the past three years including today. *If this is the first time the client has been homeless in the past 3 years then the response is One Time.* • *A NEW EPISODE SHOULD BE COUNTED AFTER EACH TIME THE CLIENT HAD HOUSING FOR 7 DAYS OR LONGER (AT A FRIEND'S OR FAMILY MEMBER'S OR OTHER NON-HOMELESS SITUATION) OR WAS IN AN INSTITUTIONAL SETTING FOR 90 DAYS OR MORE.*	☐ One Time ☐ Two Times ☐ Three Times ☐ Four or more times ☐ Client Doesn't Know ☐ Client Refused
3.4: Total number of months on the street, in ES or SH in the past 3 years: *the number of cumulative but not necessarily consecutive months spent homeless.*	Number of Months

CLIENT LOCATION

Choose the continuum where the client is located (in most cases this will be "IL-511 SubCook")

☐ IL-502 Waukegan/North Chicago/Lake Cty
☐ IL-506 Joliet/Kendall/Grundy/Will County
☐ IL-509 De Kalb
☐ IL-511 SubCook
☐ IL-512 Bloomington/Central Illinois/Kankakee
☐ IL-514 DuPage
☐ IL-517 Aurora/Elgin/Kane
☐ IL-518 Northwest/LaSalle

Enter City the client most closely associates with—this might be the city of their last permanent address or it might be the city where the client currently spends the most time.

CLIENT ZIP: _____

CLIENT CITY: _____

CLIENT'S RESIDENCE (SSVF LAST PERMANENT ADDRESS)

For SSVF Projects, this is where the client lived for 90 days or more before coming to your project

Client's Street Address				Apt #	
City, Township		State		Zip	
Address Data Quality	☐ Full Address Reported ☐ Incomplete or estimated address reported ☐ Client Does Not Know ☐ Client Refused				
Home Phone #		Cell Phone #		Alternate Contact	
Email Address					
Start Date		End Date			
Address Type	☐ After Program ☐ Before Program ☐ Before Program-Last Permanent ☐ Program (while in your project)				
Client's Residence Notes					

EMERGENCY CONTACT (OPTIONAL)

Contact's Name					
Contact's Address				Apt #	
Contact's City		Contact's State		ZIP	
Phone #		Second Phone #			
Relationship to Client					
Start Date		End Date			
Is there a release of information to contact this person?	☐ Yes ☐ No				

CITY OF EVANSTON ASSOCIATION *Eligibility for some projects requires a previous association with Evanston such as work, former address, kids in schools, or family in Evanston.*

Do you have a previous connection to Evanston?

☐ Yes ☐ No

Continue to Household Income

HOUSEHOLD INCOME

Does the household have any current income?

☐ Yes ☐ No ☐ Client Does Not Know ☐ Client Refused

If No, answer the following question and move on to Household Income for AMI Below:

Do you need assistance in applying for cash benefits? ☐ Yes ☐ No

If Yes: Please indicate in each source if the household receives the income, and if they do, the household member receiving the income, the monthly amount (to the nearest dollar) of each source, and the income start date.

		HH Member	Amount	Start Date	HH Member	Amount	Start Date
Earned Income							
☐ Yes ☐ No	If Yes:		$			$	
			$			$	
Unemployment Insurance							
☐ Yes ☐ No	If Yes:		$			$	
SSI: Supplemental Security Income							
☐ Yes ☐ No	If Yes:		$			$	
SSDI: Social Security Disability Income							
☐ Yes ☐ No	If Yes:		$			$	
VA Service Connected Disability Compensation							
☐ Yes ☐ No	If Yes:		$			$	
Private Disability Insurance							
☐ Yes ☐ No	If Yes:		$			$	
Worker's Compensation							
☐ Yes ☐ No	If Yes:		$			$	
TANF: Temporary Assistance for Needy Families							
☐ Yes ☐ No	If Yes:		$			$	
General Assistance							
☐ Yes ☐ No	If Yes:		$			$	
Retirement Income from Social Security							
☐ Yes ☐ No	If Yes:		$			$	
VA Non-Service Connected Disability Pension							
☐ Yes ☐ No	If Yes:		$			$	
Pension or retirement income from another job							
☐ Yes ☐ No	If Yes:		$			$	
Child Support							
☐ Yes ☐ No	If Yes:		$			$	
Alimony or Other Spousal Support							
☐ Yes ☐ No	If Yes:		$			$	
Other Source (specify):							
☐ Yes ☐ No	If Yes:		$			$	

*For Each **Individual** Household Member with income, record their individual total income from all sources below*

Household Member	Total Monthly Income

Household Member	Total Monthly Income

TOTAL MONTHLY HOUSEHOLD INCOME $_____ **NUMBER OF HOUSEHOLD MEMBERS** _____

FY2021 AREA MEDIAN INCOME (AMI)

Household Size	1	2	3	4	5	6	7	8
15% AMI	$817	$934	$1,050	$1,165	$1,259	$1,352	$1,446	$1,538
30% AMI	$1,633	$1,867	$2,100	$2,329	$2,517	$2,704	$2,892	$3,075
50% AMI	$2,721	$3,108	$3,496	$3,883	$4,196	$4,508	$4,817	$5,129
80% AMI	$4,350	$4,971	$5,592	$6,213	$6,713	$7,208	$7,704	$8,204
100% AMI	$5,442	$6,217	$6,992	$7,767	$8,392	$9,017	$9,633	$10,258

TOTAL MONTHLY HOUSEHOLD INCOME AS PERCENTAGE OF AMI:

☐ BELOW 30% ☐ 30%-49% ☐ 50%-79% ☐ 80%-99% ☐ 100% and above

50% AND ABOVE

ILLINOIS RIN# OPTIONAL *(ILLINOIS RECIPIENT IDENTIFICATION NUMBER FOR NON-CASH BENEFITS AND HEALTH INSURANCE)*

NON-CASH BENEFITS

Does the household currently receive any Non-Cash Benefits?

☐ Yes ☐ No ☐ Client Does Not Know ☐ Client Refused

If No - Do you need assistance in applying for non-cash benefits? ☐ Yes ☐ No

Please indicate which of the following non-cash benefits have you received over the last 30 days.
(You may use "All" if all household members receive the benefit)

		Start Date	Amount (optional)
Supplemental Nutrition Assistance Program (Food Stamps)			
☐ Yes ☐ No	If Yes, Household Members:		
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)			
☐ Yes ☐ No	If Yes, Household Members:		
TANF child care services			
☐ Yes ☐ No	If Yes, Household Members:		
TANF transportation services			
☐ Yes ☐ No	If Yes, Household Members:		
Other TANF-Funded Services			
☐ Yes ☐ No	If Yes, Household Members:		
Other Source (specify):			
☐ Yes ☐ No	If Yes, Household Members:		

COVERED BY HEALTH INSURANCE

Do household members currently have health insurance?

☐ Yes ☐ No ☐ Client Does Not Know ☐ Client Refused

If No - Do you need assistance in applying for Health Insurance? ☐ Yes ☐ No

Continue to the MCO question and Health Insurance Sub-Assessment

Medicaid MCO or Health Insurance Provider:

☐ Aetna ☐ Blue Cross (BCBSIL) ☐ Cigna ☐ County Care
☐ Harmony ☐ Humana ☐ Illinicare ☐ Meridian
☐ Molina ☐ NextLevel ☐ Out of State ☐ United
☐ Not Applicable (N/A)

Complete the following *(You may use "All" if all household members receive the benefit)*

		Start Date
Medicaid		
☐ Yes ☐ No	If Yes, Household Members:	
Medicare		
☐ Yes ☐ No	If Yes, Household Members:	
Illinois All Kids (State Children's Health Insurance Program)		
☐ Yes ☐ No	If Yes, Household Members:	
Veteran's Administration Medical Services		
☐ Yes ☐ No	If Yes, Household Members:	
Employer Provided Health Insurance		
☐ Yes ☐ No	If Yes, Household Members:	
Health Insurance obtained through COBRA		
☐ Yes ☐ No	If Yes, Household Members:	
Private Pay Health Insurance		
☐ Yes ☐ No	If Yes, Household Members:	
State Health Insurance for Adults		
☐ Yes ☐ No	If Yes, Household Members:	
Indian Health Services Program		
☐ Yes ☐ No	If Yes, Household Members:	
Other		
☐ Yes ☐ No	If Yes, Household Members:	
If "Yes" to Other, Specify Source:		

end of health insurance questions

Do you have a case worker with the Illinois Department of Child and Family Services (DCFS)? *If yes, you might be eligible for housing assistance through DCFS.*

☐ Yes ☐ No ☐ Not Applicable

Have you ever been involved in the child welfare system? ☐ Yes ☐ No ☐ Not Applicable
If Yes, did you age out of the foster care system? ☐ Yes ☐ No ☐ Not Applicable

This means you were in foster care when you became of age (18-21), you were not adopted, and you were not reunified with family. Instead you were recognized as an adult and freed from the foster care system.

If yes to both questions, you might be eligible for housing assistance through DCFS.

All Applicants Must Sign Below

By signing below, I attest that the information I have provided for eligibility and intake is a true and accurate account of the current situation, income and household.

Client signature: _____ Date: _____

Agency Representative signature: _____ Date: _____

Agency Representative Name (print): _____

SUBCOOK HOMELESSNESS PREVENTION SUPPLEMENTAL (ALL HP PROJECTS)

Referred from other program?	_____
Food Stamp status at time of intake:	☐ Currently Enrolled ☐ Enrolled at Intake ☐ Ineligible
LIHEAP status at time of intake:	☐ Currently Enrolled ☐ Enrolled at Intake ☐ Ineligible
Reason client is seeking assistance:	☐ Maintain current housing ☐ Move from current residence to other permanent housing ☐ Move from shelter to permanent housing

IDHS ETH/EF&S SUPPLEMENTAL (IDHS ETH ONLY)

Number of other shelters used in prior year:	☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more
Food Stamp status at time of intake:	☐ Currently Enrolled ☐ Enrolled at Intake ☐ Ineligible
Emancipated minor or unaccompanied youth?	☐ Yes ☐ No
Ex-offender?	☐ Yes ☐ No
Have you ever been convicted of a felony?	☐ Yes ☐ No
Pregnant Now?	☐ Yes ☐ No ☐ Client Does Not Know ☐ Client Refused
Is juvenile a parent (under age 18)?	☐ Yes ☐ No

HOMELESSNESS PREVENTION/ RAPID RE-HOUSING - Eligibility Checklist

DOCUMENTATION OF HARDSHIP

Select the situation(s) that caused you to need assistance. All hardships must be documented and verified.

☐ Loss of income/job
☐ Medical Expenses
☐ Release from institution
☐ Homeless
☐ Natural Disaster/Fire
☐ Displacement by Gov.
☐ Loss of hours at work
☐ Car Repair
☐ Condemnation
☐ Other Applicable _____
☐ Funeral Expenses
☐ Foreclosure

Describe Current Crisis/Need for Assistance/Housing Situation:

DETERMINATION OF ALTERNATIVE HOUSING OPTIONS

⇨ Is the household unable to identify appropriate subsequent housing options; ***AND*** do they lack the financial resources and support networks needed to obtain immediate housing or remain in existing housing? ☐ YES ☐ NO

⇨ Is the household unable to relocate with another family member or friends? ☐ YES ☐ NO

⇨ Does the household ***lack sufficient*** savings or other assets that can be used to pay rent, arrearages and other housing costs? (Must provide statements for any bank accounts) ☐ YES ☐ NO

If No, Total savings/assets: _____

Eligibility Criteria by Program Type	**ESG Prevention**	**ESG Rapid Re-housing**	**READE Prevention**	**IDHS Prevention**
Housing Status	☐ **IMMINENTLY AT RISK OF BECOMING HOMELESS**	☐ **LITERALLY HOMELESS IN SUBURBAN COOK COUNTY 2 WEEKS OR MORE**		☐ **IMMINENTLY AT RISK OF BECOMING HOMELESS**
Current or Last Permanent Address	☐ **IN SUBURBAN COOK COUNTY FOR AT LEAST 1 MONTH**	☐ **IN SUBURBAN COOK COUNTY WITHIN LAST SIX MONTHS**	☐ **IN SOUTH REGION OF SUBURBAN COOK COUNTY**	☐ **IN ILLINOIS**
Income	☐ **BELOW 30% AMI**	**NO INCOME RESTRICTION AT INITIAL INTAKE - BELOW 30% AMI AT REDETERMINATION ONLY**		☐ **INCOME SUFFICIENT TO COVER RENT**
Evidence of Hardship	☐ **REQUIRED**		☐ **REQUIRED**	☐ **REQUIRED**
No Alternative Housing Options	☐ **REQUIRED**	☐ **REQUIRED**		☐ **REQUIRED**
Can Case Manager Vouch Client Has Good Moral Character			☐ **REQUIRED**	
Proof that client has worked in State of Illinois			☐ **REQUIRED**	
Previous Benefit	☐ **NO ESG ASSISTANCE IN LAST 36 MONTHS**	☐ **NO ESG ASSISTANCE IN LAST 36 MONTHS**		☐ **NO IDHS HP ASSISTANCE IN PREVIOUS 2 YEARS**

Head of Household Name: _____

Initial Intake Assessment
HH Member Supplemental

HMIS CLIENT ID#

Fill-in after ServicePoint Entry

Entry Date (Project Start)

Month / Day / Year

NAME OF HOUSEHOLD MEMBER (first, middle, last name, suffix (e.g., Jr, Sr, III))				Client does not know	Client refused
First Name		Middle Name		☐	☐
Last Name		Alias/Suffix		☐	☐
SSN			Approx. or Partial SSN Reported ☐	☐	☐
Veteran Status	☐ Yes ☐ No	*Veteran Status is on the Client Profile Tab and may need to be updated if the client is already in ServicePoint.*		☐	☐
Relationship (to HoH)	☐ HoH's Child ☐ HoH's Spouse/Partner	☐ HoH's Other Relation ☐ Other: Non-Relation		*NA*	*NA*
Date of Birth			Approx. or Partial DOB Reported ☐	☐	☐
Gender	☐ Male ☐ Female	☐ Trans Female: M to F ☐ Trans Male: F to M	☐ Gender Non-Confirming (i.e. not exclusively M or F)	☐	☐
Ethnicity	☐ Non-Hispanic/Latino	☐ Hispanic/Latino		☐	☐
Primary Race	☐ American Indian or Alaskan Native ☐ Asian	☐ Black/African American ☐ White	☐ Native Hawaiian or Other Pacific Islander ☐ Other	☐	☐
Secondary Race (Leave Blank if None)	☐ American Indian or Alaskan Native ☐ Asian	☐ Black/African American ☐ White	☐ Native Hawaiian or Other Pacific Islander ☐ Other	NA	NA
Primary Language	☐ English	☐ Spanish	☐ Other, specify:		
Domestic Violence Victim/Survivor	☐ Yes	☐ No		☐	☐
	(If Yes) how long ago was the last incident? ☐ Within the past 3 months ☐ 3-6 months ago ☐ 6-12 months ago ☐ More than a year ago ☐ Client Doesn't Know ☐ Client Refused (If Yes) are you currently fleeing? ☐ Yes ☐ No ☐ Client Does Not Know ☐ Client Refused				

ILLINOIS RIN# OPTIONAL *(ILLINOIS RECIPIENT IDENTIFICATION NUMBER FOR NON-CASH BENEFITS AND HEALTH INSURANCE)*

Continue to Disability Assessment

Client Name:

DISABILITY ASSESSMENT

Does the client have a disabling condition expected to be of long duration and impedes ability to live independently? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused

Disability Type	(If Yes) Start Date	Will the Condition be long term?	Disability Determination	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?
Alcohol Abuse ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	Notes:			
Drug Abuse ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	Notes:			
Alcohol and Drug Abuse ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	Notes:			
Chronic Health Condition ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	Notes:			
HIV/AIDS ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	Notes:			
Mental Health Problem ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	Notes:			
Developmental Disability ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	Notes:			
Physical Disability ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	Notes:			

Do you have a case worker with the Illinois Department of Child and Family Services (DCFS)?
☐ Yes ☐ No ☐ Not Applicable

Have you ever been involved in the child welfare system? ☐ Yes ☐ No ☐ Not Applicable
If Yes, did you age out of the foster care system? ☐ Yes ☐ No ☐ Not Applicable

This means you were in foster care when you became of age (18-21), you were not adopted, and you were not reunified with family. Instead you were recognized as an adult and freed from the foster care system.