HPRP (Homelessness Prevention and Rapid Re-Housing) Client Intake

Grantee Name: _____ **Date:** _____

Agency Name: _____ **Interviewer:** _____

Client Identification

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

Date of Birth: _____ /_____ /_____ **SSAN:** _____ - _____ - _____

☐ Full ☐ Approximate or Partial ☐ Don't Know ☐ Refused ☐ Full ☐ Approximate or Partial ☐ Don't Know ☐Refused

Client Address: _____ **Apt #** _____

City _____ **St**_____ **Zip** _____ **Client Phone #** (____)_____-_____

Client's Relationship to Head of Household: ☐ Self ☐ Other _____

Please list all members of the household below

Last Name, First Name	DOB	Gender	Relationship to Head of Household	SSAN

Households with adults only and no children under 18 regardless of marital status are not categorized as a family for this program.

Employed? ☐ Yes ☐ No **Length of last employment**_____

Employer Name, Address and Phone # _____

Emergency Contact Name: _____ **Phone #** (____)_____-_____

Landlord Name _____

Landlord Address: _____ **Apt #** _____

City _____ **St**_____ **Zip** _____ **Landlord Phone #** (____)_____-_____

Client HMIS Assessment

Housing Status

☐	Literally homeless	☐	Housed and at **imminent** risk of losing housing
☐	Housed and at risk of losing housing	☐	Don't know
☐	Stably housed - Rent	☐	Refused

Prior Residence

☐	Emergency shelter	☐	Psychiatric hospital or other psychiatric facility
☐	Transitional housing for homeless persons	☐	Rental by client with other, non-VASH housing subsidy
☐	Permanent housing for formerly homeless persons	☐	Owned by client, with housing subsidy
☐	Rental by client, no housing subsidy	☐	Substance abuse treatment facility or detox center
☐	Owned by client, no housing subsidy	☐	Hospital, non-psychiatric
☐	Staying or living in family member's room, apt. or house	☐	Jail, prison or juvenile detention facility
☐	Staying or living in friend's room, apt or house	☐	Foster care home or foster care group home
☐	Hotel or motel paid for without emergency shelter voucher	☐	Other
☐	Place not meant for human habitation (vehicle, street, park, etc.)	☐	Don't know
☐	Safe haven	☐	Refused
☐	Rental by client, VASH subsidy		

Length of Stay: _____ (last stable 90 day residence) **Prior Zip Code: _____ Quality**: ☐ Full ☐ Don't Know ☐ Refused

HPRP (Homelessness Prevention and Rapid Re-Housing) Client Intake

Grantee Name: _____ **Date:** _____

Agency Name: _____ **Interviewer:** _____

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

Date of Birth: _____ /_____ /_____ **SSAN:** _____ - _____ - _____

Client HMIS Assessment (continued)

Ethnicity ☐ Hispanic ☐ Non-Hispanic

Race

☐	American Indian/Alaskan Native	☐	American Indian/Alaskan Native and White
☐	Asian	☐	Asian & White
☐	Black/African American	☐	Black/ African American & White
☐	Native Hawaiian /other Pacific Islander	☐	American Indian/Alaskan Native &Black African Am.
☐	White	☐	Other/Balance

☐ **Veteran?**
Were you ever enrolled in the armed forces?

☐ **Disabling Condition?**

☐	Mental Illness	☐	Developmental Disability
☐	Alcohol Abuse	☐	Physical Abuse
☐	Drug Abuse	☐	Domestic Violence
☐	HIV/AIDS Related Disease	☐	Other (specify)

Income: Income received from any source in past 30 days? ☐ Yes ☐ No ☐ Don't Know ☐ Refused
Non-cash benefit received from in past 30 days? ☐ Yes ☐ No ☐ Don't Know ☐ Refused

Cash Income

Type	Monthly Amt	Description
Earned Income		
Unemployment Insurance		
Supplemental Security Income		
Social Security Disability Income		
Veteran's Disability Payment		
Private Disability Insurance		
Worker's Compensation		
TANF		
General Assistance		
Retirement (Social Security)		
Veteran's Pension		
Other Pension		
Child Support		
Alimony		
Other Income		
No Financial Resources		
Total Monthly Cash Income		

Non-Cash Income

Type	Monthly Amt	Description
MEDICAID		
MEDICARE		
State Children's Health Insurance Program		
Special Supplemental Nutrition Program for Women, Infants, and Children		
Veteran's Administration Medical Services		
TANF Child Care Services		
TANF Transportation Services		
Other TANF-funded Services		
Section 8, Public Housing, or Other Rental Assistance		
Other Source		
Total Monthly NON-Cash Income		

HPRP (Homelessness Prevention and Rapid Re-Housing) Client Intake

Grantee Name: _____ **Date:** _____

Agency Name: _____ **Interviewer:** _____

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

Date of Birth: _____ /_____ /_____ **SSAN:** _____ - _____ - _____

Client Assistance Provided

Have you received assistance from any other agency? City/Town of assistance: _____

Eviction prevention ☐Yes ☐No -If yes: When? _____ by whom? _____

Rapid Re-Housing ☐Yes ☐No -If yes: When? _____ by whom? _____

New Assistance Provided

Service Provided	Date of Service	Monthly Value ($)	Number of Months	Period Covered	Check Number	Paid To
Case Management_HPRP						
Credit Repair						
Housing Search and Placement						
Legal Service						
Motel And Hotel Vouchers						
Moving Cost Assistance						
Outreach and Engagement						
Rental Assistance						
Security Deposits						
Utility Deposits						
Utility Payments						

Note: Participants can only receive HPRP assistance from one municipality/organization for each service in any given month.
Refer to HMIS to avoid duplication of services/assistance)
Total period of assistance cannot exceed 18 months for rental assistance and 18 months for utilities

HPRP (Homelessness Prevention and Rapid Re-Housing) Client Intake

Grantee Name: _____ **Date:** _____

Agency Name: _____ **Interviewer:** _____

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

Date of Birth: _____ /_____ /_____ **SSAN:** _____ - _____ - _____

Client Assistance Provided (continued)

New Assistance Provided

Service Provided	Date of Service	Monthly Value ($)	Number of Months	Period Covered	Check Number	Paid To
Case Management_HPRP						
Credit Repair						
Housing Search and Placement						
Legal Service						
Motel And Hotel Vouchers						
Moving Cost Assistance						
Outreach and Engagement						
Rental Assistance						
Security Deposits						
Utility Deposits						
Utility Payments						

Note: Participants can only receive HPRP assistance from one municipality/organization for each service in any given month. Refer to HMIS to avoid duplication of services/assistance)
Total period of assistance cannot exceed 18 months for rental assistance and 18 months for utilities

HPRP (Homelessness Prevention and Rapid Re-Housing) Client Intake

Grantee Name: _____ **Date:** _____

Agency Name: _____ **Interviewer:** _____

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

Date of Birth: _____ /_____ /_____ **SSAN:** _____ - _____ - _____

Client Outcome Assessment

Destination when leaving program

	Permanent Destinations		Temporary Destinations
☐	Permanent supportive housing for formerly homeless persons (such as SHP, S+C, or SRO Mod Rehab)	☐	Emergency shelter, including hotel or motel paid for with emergency shelter voucher
☐	Rental by client, no housing subsidy	☐	Transitional housing for homeless persons (including homeless youth)
☐	Rental by client, VASH housing subsidy	☐	Staying or living with family, temporary tenure
☐	Rental by client, other (non-VASH) housing subsidy	☐	Staying or living with friend, temporary tenure
☐	Owned by client, no housing subsidy	☐	Hotel or motel paid for without emergency shelter voucher
☐	Owned by client, with housing subsidy	☐	Place not meant for human habitation
☐	Staying or living with family, permanent tenure	☐	Safe Haven
☐	Staying or living with friend, permanent tenure		
	Institutional Destinations		**Other Destinations**
☐	Psychiatric hospital or other psychiatric facility	☐	Other
☐	Substance abuse treatment facility or detox center	☐	Deceased
☐	Hospital (non-psychiatric)	☐	Don't know / refused
☐	Jail, prison or juvenile detention facility	☐	Missing this information
☐	Foster care home or foster care group home		

Did assistance result in the following?

☐	Found new employment	☐	Received another housing subsidy
☐	Health Stability	☐	Stronger credit
☐	Increased income through training	☐	Training opportunity
☐	New housing		

HPRP (Homelessness Prevention and Rapid Re-Housing) Client Intake

Grantee Name: _____ **Date:** _____

Agency Name: _____ **Interviewer:** _____

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

Date of Birth: _____ /_____ /_____ **SSAN:** _____ - _____ - _____

Client Follow-Up Assessments

☐ **3 months after program exit - Assessment Date** _____

Is the participant still stably housed in the unit in which eviction prevention assistance was provided for or placed in through rapid re-housing? ☐ **Yes** ☐ **No**

Housing Status

☐	Literally homeless	☐	Housed and at **imminent** risk of losing housing
☐	Housed and at risk of losing housing	☐	Don't know
☐	Stably housed - Rent	☐	Refused

Current Residence

☐	Rental housing	☐	Emergency shelter	☐	Other
☐	Other subsidy	☐	Institution	☐	Don't know

Income: Income received from any source in past 30 days? ☐ Yes ☐ No ☐ Don't Know ☐ Refused

Non-cash benefit received from in past 30 days? ☐ Yes ☐ No ☐ Don't Know ☐ Refused

Cash Income **Non-Cash Income**

Type	Monthly Amt	Description	Type	Monthly Amt	Description
Earned Income			MEDICAID		
Unemployment Insurance			MEDICARE		
Supplemental Security Income			State Children's Health Insurance Program		
Social Security Disability Income			Special Supplemental Nutrition Program for Women, Infants, and Children		
Veteran's Disability Payment			Veteran's Administration Medical Services		
Private Disability Insurance			TANF Child Care Services		
Worker's Compensation			TANF Transportation Services		
TANF			Other TANF-funded Services		
General Assistance			Section 8, Public Housing, or Other Rental Assistance		
Retirement (Social Security)			Other Source		
Veteran's Pension					
Other Pension					
Child Support					
Alimony					
Other Income					
No Financial Resources					
Total Monthly Cash Income			**Total Monthly NON-Cash Income**		

HPRP (Homelessness Prevention and Rapid Re-Housing) Client Intake

Grantee Name: _____ **Date:** _____

Agency Name: _____ **Interviewer:** _____

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

Date of Birth: _____ /_____ /_____ **SSAN:** _____ - _____ - _____

Client Follow-Up Assessments

☐ **6 months after program exit - Assessment Date** _____

Is the participant still stably housed in the unit in which eviction prevention assistance was provided for or placed in through rapid re-housing? ☐ **Yes** ☐ **No**

Housing Status

☐	Literally homeless	☐	Housed and at **imminent** risk of losing housing
☐	Housed and at risk of losing housing	☐	Don't know
☐	Stably housed - Rent	☐	Refused

Current Residence

☐	Rental housing	☐	Emergency shelter	☐	Other
☐	Other subsidy	☐	Institution	☐	Don't know

Income: Income received from any source in past 30 days? ☐ Yes ☐ No ☐ Don't Know ☐ Refused

Non-cash benefit received from in past 30 days? ☐ Yes ☐ No ☐ Don't Know ☐ Refused

Cash Income **Non-Cash Income**

Type	Monthly Amt	Description	Type	Monthly Amt	Description
Earned Income			MEDICAID		
Unemployment Insurance			MEDICARE		
Supplemental Security Income			State Children's Health Insurance Program		
Social Security Disability Income			Special Supplemental Nutrition Program for Women, Infants, and Children		
Veteran's Disability Payment			Veteran's Administration Medical Services		
Private Disability Insurance			TANF Child Care Services		
Worker's Compensation			TANF Transportation Services		
TANF			Other TANF-funded Services		
General Assistance			Section 8, Public Housing, or Other Rental Assistance		
Retirement (Social Security)			Other Source		
Veteran's Pension					
Other Pension					
Child Support					
Alimony					
Other Income					
No Financial Resources					
Total Monthly Cash Income			**Total Monthly NON-Cash Income**		

HPRP (Homelessness Prevention and Rapid Re-Housing) Client Intake

Grantee Name: _____ **Date:** _____

Agency Name: _____ **Interviewer:** _____

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

Date of Birth: _____ /_____ /_____ **SSAN:** _____ - _____ - _____

Authorization for Information Disclosure and Document Release For Homelessness Prevention and Rapid Re-Housing Grantees and Their Agents

To:

Congregations Linked In Urban Strategy To Effect Renewal, Inc (CLUSTER)
HOPE Community Services
Legal Services of the Hudson Valley
Mount Vernon United Tenants
The Bridge Fund
Westchester Coalition for the Hungry and Homeless, Inc
Westchester Residential Opportunities
Westhab

City of Mount Vernon, City of New Rochelle, City of Yonkers, County of Westchester
***Westchester County Department of Social Services**
***Section 8, Mount Vernon, New Rochelle, Yonkers, Westchester County**
***Con Edison**
***Landlord**

_____

_____

I _____ am requesting that I and my family/household be considered for financial assistance and services, pursuant to the Homelessness Prevention and Rapid Re-Housing Program, in addition to any other grant or subsidy for which I may be eligible.

I understand that personal information may be requested concerning me and other members of my household, in connection with my application for said assistance. I understand that I am not required to authorize disclosure, discussion or release of documents. However, I may not be eligible for assistance if I do not provide such information.

I agree that information that I give to _____ or any other agency named above, now or within the next two years, or which they may already possess, may be released to agencies named above, in connection with determining eligibility and reporting to the extent necessary or appropriate.

I certify that the information being provided is true and accurate. I understand that false claims or statements may be prosecuted, which could result in civil or criminal penalties.

This release is not intended to authorize release of Personal Health Information unless otherwise stated. This release does not require any agency to release confidential information if otherwise prohibited by State or Federal law.

The above parties shall not be deemed liable for erroneous disclosure made in good faith. This release is made in connection with a request for benefits or services, but does not guarantee that I will receive assistance.

_____
Client Signature

_____
Printed Client Name

_____
Date

*** These parties may seek to verify information or provide information related to and in connection with a request for assistance on your behalf or for the benefit of your household.**