## **HOPWA** Assessment Form

Updated: 2016 October 2



Client first name:	Client last name:	MAACLink Client ID:		
Assessment date:		Assessment type:   Entry  Interval	) Exit	
	nt doesn't know nt refused	Disabling condition: Yes Client doesn't kn	ow	
Housing status:  Category 1 – Homeless Category 3 – Homeless only under other Stably housed – rent Client doesn't know Client  Prior type of residence: Emergency shelter (inc. hotel/motel vou Permanent housing for formerly homele Substance abuse treatment facility or de Jail, prison, or juvenile detention facility	Category 2 – At imminent risk of losing housing Category 4 – Fleeing domestic violence At risk of homelessness  Transitional housing for homeless persons Psychiatric hospital/facility Hospital or other residential non-psych. med. facility Staying/living in a family member's room/apt/house			
Staying/living in a friend's room/apt/house  Foster care home or foster care group home  Safe Haven  Rental by client with GPD TIP subsidy  Rental by client (no ongoing subsidy)  Owned by client with ongoing subsidy  Long-term care facility/nursing home		Hotel/motel paid w/o emergency shelter voucher Place not meant for habitation Rental by client with VASH subsidy Rental by client with other ongoing subsidy Residential project/halfway house (no homeless criteria) Owned by client (no ongoing subsidy) Interim housing Client refused		
Length of stay in prior residence:  One night or less One week or more but less than one month One month or more but less than 90 days 90 days or more but less than one year One year or longer Client doesn't know Client refused		Approximate date homelessness started:		
Number of times client has been on the streets, in emergency shelter, or in safe haven in the past three years including today:  One time Two times Three times Client doesn't know Client refused		(Cumulative) Number of months on the streets, in eme shelter, or in safe haven in the past three years:	rgency	
Client has special needs:  Yes No		Physical disability:  Yes No Client doesn't know Client relationship.		
If Yes, complete one or more of the following special need detail sections. If No, skip to next section.		<ul> <li>Yes ○ No ○ Client doesn't know ○ Client release Receiving treatment:</li> <li>Yes ○ No ○ Client doesn't know ○ Client release Documentation on file (mark if Yes): ○</li> </ul>		
Mental health problem:  Yes No Client doesn't know Indefinite:	Client refused	HIV/AIDS:  Yes No Client doesn't know Client re Indefinite:		
<ul> <li>Yes  ○ No  ○ Client doesn't know</li> <li>Receiving treatment:</li> <li>Yes  ○ No  ○ Client doesn't know</li> <li>Documentation on file (mark if Yes): ○</li> </ul>	<ul><li>Client refused</li><li>Client refused</li></ul>	<ul> <li>✓ Yes</li> <li>✓ No</li> <li>✓ Client doesn't know</li> <li>✓ Client respectively.</li> <li>✓ Yes</li> <li>✓ No</li> <li>✓ Client doesn't know</li> <li>✓ Client respectively.</li> <li>✓ Client respectively.</li> </ul>		

Developmental disability:	Chronic health condition:		
	Yes No Client doesn't know Client refused		
Indefinite:	Indefinite:		
	Yes No Client doesn't know Client refused		
Receiving treatment:	Receiving treatment:		
	Yes No Client doesn't know Client refused		
Documentation on file (mark if Yes):	Documentation on file (mark if Yes):		
Substance abuse:	Domestic violence experience:		
<ul><li>Drug abuse</li><li>Both alcohol and drug abuse</li></ul>	Yes No Client doesn't know Client refused		
○ Client doesn't know ○ Client refused	(If Yes) When experience occurred:		
Indefinite:	○ In the past three months ○ Three to six months ago		
○ Yes    ○ No    ○ Client doesn't know    ○ Client refused	○ Six to twelve months ago ○ More than one year ago		
Receiving treatment:	○ Client doesn't know ○ Client refused		
○ Yes    ○ No    ○ Client doesn't know    ○ Client refused	(If Yes) Currently fleeing domestic violence:		
Documentation on file (mark if Yes):	○ Yes    ○ No    ○ Client doesn't know    ○ Client refused		
Client receiving public HIV/AIDS medical assistance:	Client receiving AIDS Drug Assistance Program (ADAP):		
○ Yes    ○ No    ○ Client doesn't know    ○ Client refused	○ Yes    ○ No    ○ Client doesn't know    ○ Client refused		
If No:	If No:		
Applied, decision pending Applied, client ineligible	Applied, decision pending Applied, client ineligible		
○ Client did not apply ○ Insurance type N/A for client	Client did not apply Insurance type N/A for client		
○ Client doesn't know ○ Client refused	○ Client doesn't know ○ Client refused		
T-cell (CD4) count available:	Viral load available:		
○ Yes ○ No ○ Client doesn't know ○ Client refused	○ Yes    ○ No    ○ Client doesn't know    ○ Client refused		
(If Yes) Data source:	(If Yes) Data source:		
○ Medical report ○ Client report ○ Other	○ Medical report ○ Client report ○ Other		
(If Yes) T-cell count: (If Yes) Viral count:			
Client is currently receiving income: Yes No Client doesn't know Client refused			
Earned income:	Unemployment insurance:		
SSI (Supplemental Security Income):	SSDI (Social Security Disability Income):		
VA Service Connected Disability Compensation:	Private disability insurance:		
Worker's compensation:	TANF (Temporary Assistance for Needy Families):		
General assistance:	Retirement income from Social Security:		
VA Non-Service Connected Disability Compensation:	Pension from a former job:		
Child support:	Alimony or other spousal support:		
Other (1):			
Client is currently receiving benefits: Yes No Client doesn't know Client refused			
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SNAP/Food stamps or food benefit card:			
WIC (Special Supplemental Nutrition Program for Women, Infants, and Children):			
TANF child care services: TANF transportation services:			
	ublic housing, or other rental assistance:		
	rental assistance:		
Other:			
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## Car payment: \_\_\_\_\_ Car repair: \_\_\_\_\_ Bus pass: \_\_\_\_\_ Child care: \_\_\_\_\_ Child support: \_\_\_\_\_ Church tithe: \_\_\_\_\_ Education: \_\_\_\_\_ Clothing: \_\_\_\_\_ Credit accounts: \_\_\_\_\_ Entertainment: \_\_\_\_\_ Food: \_\_\_\_\_ Electricity (utility): \_\_\_ Gas/heating oil (utility): \_\_\_\_ Gasoline (car) : \_\_\_\_\_\_ Garnishments (on wage/salary): \_ Health insurance: \_\_\_\_\_ Other insurance: \_\_\_\_\_ Laundry: Medical: \_\_\_\_\_ Legal: Med prescription: \_\_\_\_\_ Miscellaneous: \_\_\_ Mortgage: \_\_\_\_\_ Payday loans: \_\_\_\_\_ Personal hygiene: \_\_\_\_\_ Personal luxuries: \_\_\_\_\_ Rent: \_\_\_\_\_ Savings: \_\_\_\_\_ Rent deposit: Retirement plan: \_\_\_\_ Taxes: \_\_\_\_\_ Unpaid rent: \_\_\_\_\_ Sewage/trash (utility): \_\_\_\_\_ Storage: Telephone (utility) : \_\_\_\_\_\_ Transportation (general): \_\_\_\_\_ Unpaid utilities: \_\_\_\_\_\_ Water (utility) : \_\_\_\_\_ Withholding tax: Other (1): \_\_\_\_\_ Other (2):\_\_\_\_\_ Insurance coverage assessment date: Client has health insurance: Client refused (If Yes) Health insurance type: Medicaid Medicare SCHIP (State Child Health Insurance Program) State Health Insurance for Adults ○ VA health insurance ○ COBRA

Private pay insurance Indian Health Services Program

Client expenses:

Employer insurance