Carroll County CoC Universal Data Assessment (Head of Household)

Complete this form for singles or the head of household.

FOR STAFF ONLY:
CSP Client ID: _____
Staff: _____
Date: _____

First Name	Middle	Last Name	Preferred Name

Social Security Number	US Military Veteran?	Date of Birth
____ - ____ - ____ ☐ Don't Know ☐ Prefer Not to Answer	☐ Yes ☐ No ☐ Prefer Not to Answer	___ / ___ / ____

Primary Language		Translation Services Needed?	☐ Yes ☐ No

Marital Status *Select one.*
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Prefer Not to Answer

Household Type *Select one.*
☐ Single Adult ☐ Female Single Parent ☐ Male Single Parent ☐ Two Parent Family ☐ Couple with no Children
☐ Grandparent(s) and Child ☐ Multigenerational ☐ Other: please specify: _____

Gender *Select all that apply.*
☐ Female ☐ Male ☐ Transgender (M->F; F->M) ☐ Non-Binary ☐ Questioning ☐ Don't Know
☐ Culturally Specific Identity (e.g. Two Spirit) ☐ Different Identity:_____ ☐ Prefer Not to Answer

Race and Ethnicity *Select all that apply.*
☐ American Indian, Alaska Native, or Indigenous ☐ Hispanic / Latina/e/o ☐ White
☐ Asian or Asian American ☐ Middle Eastern or North African ☐ Don't Know
☐ Black, African American, or African ☐ Native Hawaiian or Pacific Islander ☐ Prefer Not to Answer

Phone Number	Email Address

Street Address	City	State	Zip

Mailing Address	City	State	Zip

Zip Code of Last Permanent Address	_____	Transportation Problem?	☐ Frequently ☐ Sometimes ☐ Never

If you are from outside Carroll County, what brought you here? *Select one.*
☐ Grew up in Carroll County ☐ Returned to Live with Family ☐ Relocated for Relationship ☐ Relocated for a Job
☐ Discharged from CHC ☐ Discharged from CCDC ☐ Recovery House ☐ Affordable Hotel
☐ Better Resources ☐ Other: _____

Do you have Health Insurance coverage? ☐ Yes *(If yes, check type(s) below)* ☐ No
☐ Medicaid ☐ Medicare ☐ State Children's Health Insurance Program ☐ Veteran's Administration Medical Services
☐ Employer-Provided Health Insurance ☐ Health Insurance through COBRA ☐ Private Pay Health Insurance
☐ State Health Insurance for Adults ☐ Indian Health Services Program ☐ Other (specify): _____

Pregnant? ☐ Yes ☐ No If Yes, Due Date: _____ ☐ Prefer Not to Answer

Do you have any of the following HUD defined Disabling Conditions? ☐ Yes *(If yes, check type(s) below)* ☐ No

	Yes	No	If yes, is it expected to be of long-continued and indefinite duration, substantially impeding the ability to live independently, and of such a nature that such ability could be improved by more suitable housing conditions?	Yes	No	Notes on Disability
Alcohol Use Disorder	☐	☐		☐	☐	
Both Alcohol and Drug Use Disorder	☐	☐		☐	☐	
Chronic Health Condition	☐	☐		☐	☐	
Developmental	☐	☐		☐	☐	
Substance Use Disorder	☐	☐		☐	☐	
HIV / AIDS	☐	☐		☐	☐	
Mental Health Disorder	☐	☐		☐	☐	
Physical Disability	☐	☐		☐	☐	

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Highest Level of Education *Select one.*

☐ No Schooling	☐ Grades 7-8	☐ High School Diploma	☐ Associate's Degree	☐ Graduate Degree
☐ Less than Grade 5	☐ Grades 9-11	☐ GED	☐ College Degree	☐ Don't Know
☐ Grades 5-6	☐ Grade 12; No Diploma	☐ Some College	☐ Vocational Cert	☐ Prefer Not to Answer

Employment Status *Select one.*

☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Disability ☐ Seasonal ☐ Temp/Casual ☐ Self-Employed ☐ Retired ☐ Other: ____

Do you have *MONTHLY* income from any source?

☐ Yes *(If yes, check type(s) below and estimate amount)* ☐ No

	Per MONTH
☐ Earned Income (i.e., employment income)	$_____
☐ Unemployment Insurance	$_____
☐ Supplemental Security Insurance (SSI)	$_____
☐ Social Security Disability (SSDI)	$_____
☐ Alimony or Other Spousal Support	$_____
☐ Child Support	$_____
☐ General Assistance (GA/TDAP)	$_____
☐ Needy Families (TANF/TCA)	$_____
☐ Pension/Retirement Income from a job	$_____
☐ Private disability insurance	$_____
☐ Retirement income from social security	$_____
☐ VA non-svc connected disability pension	$_____
☐ VA svc connected disability compensation	$_____
☐ Worker's Compensation	$_____
☐ Other Source (specify): _____	$_____

Total *MONTHLY* Income: $ _____

Do you receive any non-cash benefits?

☐ Yes *(If yes, check type(s) below)* ☐ No

- ☐ SNAP (Food Stamps) $_____
- ☐ Special Supp. Nutrition Program for WIC
- ☐ TANF Child Care Services
- ☐ TANF Transportation Services
- ☐ Other TANF-Funded Services
- ☐ Other Source (specify): _____

Please add any income that children under 18 receive to the head of household's monthly income information.

What are the primary and secondary reasons you are experiencing housing instability? *Select two.*

1	2		1	2		1	2	
☐	☐	Criminal Activity	☐	☐	Loss of Public Assistance	☐	☐	Release from an Institution
☐	☐	Domestic Violence Survivor	☐	☐	Loss of Transportation	☐	☐	Substance Abuse
☐	☐	Eviction	☐	☐	Medical Condition	☐	☐	Substandard Housing
☐	☐	Eviction by Family	☐	☐	Mental Health	☐	☐	Underemployment / Low Income
☐	☐	Health / Safety	☐	☐	Mortgage Foreclosure	☐	☐	Utility Shutoff
☐	☐	Loss of Child Care	☐	☐	No Affordable Housing	☐	☐	Other: _____
☐	☐	Loss of Job	☐	☐	Previous Home Condemned			

Have you experienced domestic violence?

☐ Yes ☐ No ☐ Don't Know ☐ Prefer Not to Answer

When did the last experience occur? Select one.	☐ Within the past 3 months	☐ 3 to 6 months ago	☐ 6 to 12 months ago	☐ More than a year ago	☐ Don't Know	☐ Prefer Not to Answer
Are you currently fleeing? Select one.	☐ Yes	☐ No	☐ Don't Know	☐ Prefer Not to Answer		
Are you in immediate danger? Are you afraid to return to where you are staying?	☐ Yes	☐ No				

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Where did you sleep last night? *Select one.*

Homeless Situation

- ☐ Place not meant for habitation (for example: car, park, abandoned building, bus station, airport, tent)
- ☐ Emergency shelter
- ☐ Hotel/motel paid for by a shelter

How long have you been staying there?

- ☐ One night or less
- ☐ Two to six nights
- ☐ One week or more, but less than a month
- ☐ One month or more, but less than 90 days
- ☐ 90 days or more, but less than one year
- ☐ One year or longer
- ☐ Don't Know
- ☐ Prefer not to answer

Approximate Date This Episode of Homelessness Began: _____

Institutional Situation

- ☐ Hospital / Residential medical facility
- ☐ Substance abuse treatment/Detox center
- ☐ Psychiatric hospital / facility
- ☐ Jail / Prison / Juvenile detention
- ☐ Long-term care facility / Nursing home
- ☐ Foster care home

Please list Name of Institution: _____

How long have you been staying there?

- ☐ One night or less
- ☐ Two to six nights
- ☐ One week or more, but less than a month
- ☐ One month or more, but less than 90 days
- ☐ 90 days or more, but less than one year
- ☐ One year or longer
- ☐ Don't Know
- ☐ Prefer not to answer

If less than 90 days, on the night BEFORE, were you staying on the streets or in a shelter? ☐ Yes ☐ No

If so, what was the approximate date you started staying on the street or in a shelter? _____

Temporary or Permanent Housing Situation

- ☐ Staying/living at friend's house
- ☐ Staying/living at family's house
- ☐ Hotel/motel paid for by you / family / friend
- ☐ Owned, no subsidy
- ☐ Owned, with a subsidy (Please specify: _____)
- ☐ Rental, no subsidy
- ☐ Rental, with a subsidy (Please specify: RRH, VASH, HCV, Other)
- ☐ Perm. Supp. Housing (not RRH)
- ☐ Host Home
- ☐ Trans. housing for homeless youth
- ☐ Residential/halfway house

How long have you been staying there?

- ☐ One night or less
- ☐ Two to six nights
- ☐ One week or more, but less than a month
- ☐ One month or more, but less than 90 days
- ☐ 90 days or more, but less than one year
- ☐ One year or longer
- ☐ Don't Know
- ☐ Prefer not to answer

If less than 7 days, on the night BEFORE, were you staying on the streets or in a shelter? ☐ Yes ☐ No

Approximate Date of This Episode of Homelessness: _____

How many TIMES have you stayed in a place not meant for habitation or an emergency shelter in the past three years (including this time if you are currently experiencing homelessness)?

☐ Zero Times ☐ One Time ☐ Two Times ☐ Three Times ☐ Four or more times

How many MONTHS have you stayed in a place not meant for habitation or an emergency shelter in the past three years (including this time if you are currently experiencing homelessness)?

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Client Acknowledgement of Data Entry into Community Services

Community Services (CS) is a Homeless Management Information System (HMIS) used by Carroll County's Continuum of Care (CoC). A HMIS is required for use by all homeless service providers funded by the Department of Housing and Urban Development (HUD). All providers entering data into CS practice high standards of confidentiality and are required to seek explicit permission from the client before releasing any identifiable client information. Client information is used by CS provider agencies to enhance service delivery and data quality among partner agencies. This information helps the agencies provide services to clients and evaluate service delivery for equity and system improvement.

By signing this document, you are acknowledging the following:

- Protected client information is handled securely and responsibly in accordance with client wishes. Information about you and your household will be entered into Community Services (CS). This information includes, but is not limited to your name, SSN, contact information, demographic information, disability, veteran, and medical insurance status, and all other HUD required client information.
- Client consent (verbal or written) must be obtained before any protected personal information can be shared, and you as the client have the right to view or keep a printed copy of your own records contained in CS.
- See the Carroll County HMIS Privacy Notice for more information on how client information is handled in Carroll County's HMIS.
- HMIS data is uploaded to the Maryland State Homeless Services Data Warehouse (MSHDW) on a quarterly basis, and de-identified data is required to be submitted to HUD and other funders throughout the year. See the MSHDW Privacy Notice for more information on how client information is handled in the MSHDW.
- CS provider agencies include Carroll County Health Department (CCHD), Carroll County Department of Citizen Services (CCDCS), and Human Services Programs of Carroll County, Inc. (HSP). These agencies can view your information in CS for the purposes stated above. You have the right not to share your information with one or more partner agencies **without affecting your eligibility status.** If you do not wish to share information with a particular agency or agencies, please advise who: _____.
- You will receive the same services whether or not you share your personal information.

_____ _____

Head of Household's Signature | Other Party

_____ _____

Date Signed | Relationship to Head of Household