

Date: \_\_\_\_\_

HOPWA Data Form : Agency Name  
(HOPWA Grant Year 04/01/2007- 03/31/2008)

Complete this form for every client receiving HOPWA services from this agency.

"HOPWA services" include:

HOPWA Case Management, Other HOPWA –Funded Supportive Services, TBRA (Fort Mill Housing Vouchers), and/or Short-Term Rent Mortgage and Utilities.

I. Individual Information

Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_ CI ID: \_\_\_\_\_  
Street

City County Zip Code Area Median Income at Entry: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Female Male Transgender

Race: \_\_\_ Asian/Pacific Islander \_\_\_ Black/African-American \_\_\_ Native American \_\_\_ White/Caucasian \_\_\_ Other

Ethnicity: \_\_\_Hispanic/Latino(a) \_\_\_Non-Hispanic/Latino(a)

II. Income Information: Provide instructions in \*( ) below:

- 1. Individual Monthly Gross Income at entry: \$ \_\_\_\_\_
- 2. Total Household Gross Income at entry (including client): \_\_\_\_\_

(If HOPWA-defined household members have income, enter the income(s) from Page 3 for each household member. Note: Total income from HOPWA-defined household members plus client income, should equal "Total Household Gross Above).

\*(Provide Instructions: Client Profile – Income –)

- 3. Total number in household: \_\_\_\_\_ (If more than client lives in household, complete "Contacts at Entry" [below]).

\*(Provide Instructions: "Client Profile" – "Contacts" – "Add" ( to create) or "Link" (to edit existing). Enter a "Contact" record for each and/HOPWA-defined Household member according to instructions for contacts on page 4. Press the button to "compute" and verify the HOPWA-defined household size.)

\*(Provide Instructions : "Program Enrollment Housing –APR Data – "Does client have income at program entry?")

III. Financial Information

Income Source (Client): Amount  
(per month)

Employment wages \$ \_\_\_\_\_  
Retirement \$ \_\_\_\_\_  
SSI/SSDI \$ \_\_\_\_\_  
Unemployment Comp. \$ \_\_\_\_\_  
Other Family/Household \$ \_\_\_\_\_  
Other/Misc. \$ \_\_\_\_\_

Total Income \$ \_\_\_\_\_

IV. Assistance Requested

Type Amount of Bill Payments by Client/other Amount Requested  
Temporary housing \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_  
Mortgage/Rent \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_  
Housing Deposit \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_  
Utilities (payment/deposit)  
Electric \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_  
Gas \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_  
Water \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_  
Fuel oil/coal/wood \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

- HOPWA Case Management
- Other HOPWA Funded Supportive Services
- Tenant-based Rental Assistance
- Facility Based Housing

Total amount requested \$ \_\_\_\_\_

I certify that I have no income at this time. \_\_\_\_\_ Initial

Client ID: \_\_\_\_\_

**Client Information Prior to Entering HOPWA Program (At Entry):**  
(This information applies to client prior to receiving HOPWA services in your program):

**Admitting Client into HOPWA Program**

**I. HOPWA Entry/Admission Date:** \_\_\_\_\_

- “New” clients: Date the client began receiving **any** HOPWA service with your agency. (This may not be “Date of Intake”).
- “Continuing” clients: Date the client first received **any** HOPWA service with your agency. (This is typically the Date of the former “HOPWA Admission” Assessment in *Provide*.)

\*(Provide Instructions: “Create” – “Program Enrollment Housing” – “Required” - “Status” and “Date of Admission”. )

**II. Housing Information Prior to Entering HOPWA (At Entry into HOPWA)**

**Number of bedrooms:** \_\_\_\_ SRO \_\_\_\_ 0 \_\_\_\_ 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4 \_\_\_\_ 5

(The following information to be completed at initial application request only.)

\*(Provide Instructions: “Program Enrollment Housing” – “APR Data”).

**III. Residence Type Prior to Entry:** \_\_\_\_

- |                                                         |                                                                     |                                                              |
|---------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------|
| 01 - Emergency shelter                                  | 06 - Hospital (non psychiatric)                                     | 13 - Staying or living in a friend's room apartment or house |
| 02 - Transitional housing for homeless persons          | 07 - Jail prison or juvenile detention facility                     | 14 - Hotel or motel paid for without emergency voucher       |
| 03 - Permanent housing for formerly homeless persons    | 08 - Don't know                                                     | 15 - Foster care home or foster care group home              |
| 04 - Psychiatric hospital or other psychiatric facility | 09 - Refused                                                        | 16 - Place not meant for habitation                          |
| 05 - Substance abuse treatment facility or detox center | 10 - Room apartment or house that you rent                          | 17 - Other                                                   |
|                                                         | 11 - Apartment or house that you own                                |                                                              |
|                                                         | 12 - Staying or living in a family member's room apartment or house |                                                              |

**IV . Length of Stay in Previous Place:** \_\_\_\_

- |                                              |                                                 |                        |
|----------------------------------------------|-------------------------------------------------|------------------------|
| 1 - One week or less                         | 3 - One to three months                         | 5 - One year or longer |
| 2 - More than one week but less than a month | 4 - More than three months but less than a year |                        |

\*(Provide Instructions : “Program Enrollment Housing- Required”)

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***Client Population/Special Needs Assessment***

**Disabling Condition Assessment:**

**a. Does client have a chronic physical illness or physical disability?** \_\_\_\_Yes \_\_\_\_No

**b. Does client have a Developmental Disability?** \_\_\_\_Yes \_\_\_\_No

**c. Does client have Mental Health Issue(s)?** \_\_\_\_Yes \_\_\_\_No

**d. Does client have a Substance Abuse issue?** \_\_\_\_Yes \_\_\_\_No

\*(Provide Instructions: These fields are to determine if client meets HOPWA definition of “Disabling Condition”. Not required to be entered for HOPWA APR.)

**If “Yes” to either question (above), client has a “Disabling Condition” as defined by HOPWA.**

**I. Does client have a Disabling Condition as defined by HOPWA?** \_\_\_\_Yes \_\_\_\_No

\*(Provide Instructions : “Program Enrollment Housing -Required”)

Client ID: \_\_\_\_\_

*Chronically Homeless Assessment:*

- a. Does client have a disabling condition? \_\_\_Yes \_\_\_No
- b. Has client been continuously homeless for year or more? \_\_\_Yes \_\_\_No
- c. Has client had at least four (4) episodes of homelessness in the past 3 years? \_\_\_Yes \_\_\_No
- d. Is client unaccompanied by another individual? \_\_\_Yes \_\_\_No

(To be considered chronically homeless, a client must have "Yes" in one of the following combinations :

- 1, 2a, 3
- 1, 2b, 3

\*(Provide Instructions: These fields are to determine if client meets HOPWA definition of "Chronically Homeless". Not required to be entered for HOPWA APR.)

**II. Is client Chronically Homeless as defined by HOPWA?** \_\_\_Yes \_\_\_No

\*(Provide Instructions : "Program Enrollment Housing -APR Data")

*Other HOPWA Required Information:*

**III. Is client a victim of domestic violence?** \_\_\_Yes \_\_\_No

\*(Provide Instructions : "Program Enrollment Housing -APR Data")

**IV. Is client a Veteran?** \_\_\_Yes \_\_\_No

\*(Provide Instructions : "Program Enrollment Housing -Required")

***Performance Measures***

**I. Has Housing Plan for establishing or maintaining stable housing been established prior to entry into HOPWA?**  
\_\_\_Yes \_\_\_No

If yes, date of initial stable Housing Plan: \_\_\_\_\_

**II. Has client had contact with a Case Manager in the last 3 months (or according to service plan) prior to entry?**  
\_\_\_Yes \_\_\_No

If yes, Date of Last Made Contact prior to entry:

**III. Has client had contact with a primary health care provider in the last 3 months (or according to service plan) prior to entry?** \_\_\_Yes \_\_\_No

If yes, Date of Last Medical Care Visit? \_\_\_\_\_

**IV. Does client have Medical Care coverage or medical assistance prior to entry?** \_\_\_Yes \_\_\_No

\*(Provide Instructions : "Program Enrollment Housing -APR Data")

Client ID: \_\_\_\_\_

### I. Contacts At Entry

Contact First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Relationship to client:  Attorney  Aunt  Brother  Cousin  Daughter  Friend  Grandparent  Husband  
 Father  Mother  Nephew  Niece  Partner  Sister  Roommate  Wife  
 Step-father  Step-mother  Son  Uncle  Other Relative  Other

OK to contact:  Yes  No

Preferred Method of contact: \_\_\_\_\_

Emergency Contact:  Yes  No

Dependent:

Cohabitant:  Yes  No

Desired Cohabitant:

Household Member:  Yes  No

Next of Kin:  Yes  No

Supportive:  Yes  No

Disabled:  Yes  No

Veteran:  Yes  No

Race: \_\_\_\_\_

Ethnicity:  Hispanic  Non-Hispanic

Date of Birth: \_\_\_\_\_

Monthly Income: \_\_\_\_\_

HIV Status:  Negative  Asymptomatic  
 Symptomatic  AIDS  Unknown

Notified of client's status:  Yes  No

Referred to partner referral program:  Yes  No

Phone Number: \_\_\_\_\_

Message:  Any  None  Name Only  Discreet

Contact Address: \_\_\_\_\_

Contact First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Relationship to client:  Attorney  Aunt  Brother  Cousin  Daughter  Friend  Grandparent  Husband  
 Father  Mother  Nephew  Niece  Partner  Sister  Roommate  Wife  
 Step-father  Step-mother  Son  Uncle  Other Relative  Other

OK to contact:  Yes  No

Preferred Method of contact: \_\_\_\_\_

Emergency Contact:  Yes  No

Dependent:

Cohabitant:  Yes  No

Desired Cohabitant:

Household Member:  Yes  No

Next of Kin:  Yes  No

Supportive:  Yes  No

Disabled:  Yes  No

Veteran:  Yes  No

Race: \_\_\_\_\_

Ethnicity:  Hispanic  Non-Hispanic

Date of Birth: \_\_\_\_\_

Monthly Income: \_\_\_\_\_

HIV Status:  Negative  Asymptomatic  
 Symptomatic  AIDS  Unknown

Notified of client's status:  Yes  No

Referred to partner referral program:  Yes  No

Phone Number: \_\_\_\_\_

Message Type:  Any  None  Name Only  Discreet

Contact Address: \_\_\_\_\_

Contact First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Relationship to client:  Attorney  Aunt  Brother  Cousin  Daughter  Friend  Grandparent  Husband  
 Father  Mother  Nephew  Niece  Partner  Sister  Roommate  Wife  
 Step-father  Step-mother  Son  Uncle  Other Relative  Other

OK to contact:  Yes  No

Preferred Method of contact: \_\_\_\_\_

Emergency Contact:  Yes  No

Dependent:

Cohabitant:  Yes  No

Desired Cohabitant:

Household Member:  Yes  No

Next of Kin:  Yes  No

Supportive:  Yes  No

Disabled:  Yes  No

Veteran:  Yes  No

Race: \_\_\_\_\_

Ethnicity:  Hispanic  Non-Hispanic

Date of Birth: \_\_\_\_\_

Monthly Income: \_\_\_\_\_

HIV Status:  Negative  Asymptomatic  
 Symptomatic  AIDS  Unknown

Notified of client's status:  Yes  No

Referred to partner referral program:  Yes  No

Phone Number: \_\_\_\_\_

Message Type:  Any  None  Name Only  Discreet

Contact Address: \_\_\_\_\_

**I. Consent and Certification**

By my signature below, I certify that the income verification herein provided is correct, and I grant consent for information regarding any housing assistance to be released to any designated HOPWA case manager requesting assistance on my behalf. I understand that information provided by me, including income and the landlord statement, may be verified by HOPWA case managers. I understand that any changes in the information I have given must be reported to my case manager. For tenant-based rental assistance services, I understand the need for on-going Case Management as a criteria for the program. The agency providing said Case Management may contact, retrieve or provide information regarding my housing status, rental agreement and/or eligibility for housing assistance with the Fort Mill Housing Services TBRA program. I certify that:

\_\_\_\_\_ I have not been served with HOPWA assistance from another agency before this request or since my last application

\_\_\_\_\_ I have been served with HOPWA assistance through \_\_\_\_\_ (agency/provider name) and give permission for this agency to release my HOPWA information to \_\_\_\_\_.

I have been given a battery operated smoke detector \_\_\_Yes \_\_\_No

Children under seven years of age live at my current residence \_\_\_Yes \_\_\_No

If yes, I have been given information on the hazards of lead paint in my home \_\_\_Yes \_\_\_No

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
Date

**II. Agency Information**

Documentation of crisis/emergency situation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referrals Made: \_\_\_\_\_  
\_\_\_\_\_

Will client's expenses exceed income following this HOPWA request? \_\_\_\_\_

**Documentation:**

Letter on letterhead \_\_\_\_\_  
Eviction notice \_\_\_\_\_  
Mortgage Company letter \_\_\_\_\_  
Bank letter \_\_\_\_\_  
Cut off notice \_\_\_\_\_  
Deposit notice \_\_\_\_\_  
Bill \_\_\_\_\_

Medical verification of HIV status \_\_\_\_\_  
Client income verification on file \_\_\_\_\_  
Household income verification on file \_\_\_\_\_  
Landlord statement on file \_\_\_\_\_  
Client's name on lease \_\_\_\_\_  
Client's name on utility bill (if no see below) \_\_\_\_\_  
External verification \_\_\_\_\_

\_\_\_\_\_  
Case Manager Signature

\_\_\_\_\_  
Date

**III. Agency Response**

Approved

Reason for denial: \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

Total: \$ \_\_\_\_\_

\_\_\_\_\_  
Supervisor signature

\_\_\_\_\_  
Date

Date: \_\_\_\_\_

HOPWA Discharge/Year-End Data Form  
(HOPWA Grant Year 04/01/2007- 03/31/2008)

Complete the indicated fields for every client receiving HOPWA services in the Grant Year at Discharge or End of Grant Year, regardless if client is being discharged or continued in HOPWA at this agency.

"HOPWA services" include:

HOPWA Case Management, Other HOPWA –Funded Supportive Services, TBRA( Fort Mill Housing Vouchers), and/or Short-Term Rent Mortgage and Utilities.

I. Individual Information (only if changed from entry into HOPWA): *Fields with an "\*" are required for discharge/year end:*

Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_ CI ID: \_\_\_\_\_  
Street

\_\_\_\_\_ \*Area for Median Income Exit: \_\_\_\_\_  
City County Zip Code

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Female Male Transgender

Race: \_\_\_ Asian/Pacific Islander \_\_\_ Black/African-American \_\_\_ Hispanic/Latino(a) \_\_\_ Native American \_\_\_ White/Caucasian \_\_\_ Other

Ethnicity: \_\_\_ Hispanic/Latino(a) \_\_\_ Non-Hispanic/Latino(a)

II. Income Information: Provide instructions in \*() below:

1. \*Individual Monthly Gross Income at Exit: \$ \_\_\_\_\_

2. \*Total Household Gross Income (including client) at exit: \_\_\_\_\_

(If HOPWA-defined household members have income changes, enter the income(s) from Contacts at Exit/ Continuing for each household member. Note: Total income from HOPWA-defined household members plus client income, should equal "Total Household Gross [Above] ).

\*(Provide Instructions: Client Profile – Income – Add or Link income information for client and contacts[household members])

3. Total number in household at exit/continuing : \_\_\_\_\_ (If more than client lives in household, complete page 3)

\*(Provide Instructions: "Client Profile" – "Contacts" – "Add" ( to create) or "Link" (to edit existing). Enter or update any "Contact" record for each HOPWA-defined Household member (changes from entry only) according to instructions on page \*. Press the button to "compute" and verify the HOPWA-defined household size.)

III. Financial Information

Income Source(Client):	Amount (per month)
Employment wages	\$ _____
Retirement	\$ _____
SSI/SSDI	\$ _____
Unemployment Comp.	\$ _____
Other Family/Household	\$ _____
Other/Misc.	\$ _____
<b>Total Income</b>	<b>\$ _____</b>

IV. Type of Additional Assistance Needed: (Continuing Only)

- TBRA On-going Case Management
- Short-term Rent Mortgage Utilities
- HOPWA Case Management
- Permanent Housing Placement
- Employment Assistance
- Facility Based Housing
- Other \_\_\_\_\_

I certify that I have no income at this time. \_\_\_\_\_ Initial

Client ID: \_\_\_\_\_

*Client Information at "Discharge" or "End" of HOPWA Grant Year:*

**"Discharging" or "Continuing" Client in HOPWA Program**

**I. HOPWA Program Status (Indicate only one) :** \_\_\_\_ a. Continuing \_\_\_\_ b. Discharged

a. **Date of Discharge:** \_\_\_\_\_

b. **Date Assessed for Continuation:** \_\_\_\_\_

\*(Provide Instructions: "Create" – "Program Enrollment Housing" – "Status" and "Date of Admission". )

**II. Housing Information at Exit (Discharge Only) :**

**Number of bedrooms:** \_\_\_\_ SRO \_\_\_\_ 0 \_\_\_\_ 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4 \_\_\_\_ 5

\*(Provide Instructions: "Program Enrollment Housing" – "Number of bedrooms where you will be staying".)

**III. Residence Type at Exit:** \_\_\_\_

01 - Emergency shelter

02 - Transitional housing for homeless persons

03 - Permanent housing for formerly homeless persons

04 - Psychiatric hospital or other psychiatric facility

05 - Substance abuse treatment facility or detox center

06 - Hospital (non psychiatric)

07 - Jail prison or juvenile detention facility

08 - Don't know

09 - Refused

10 - Room apartment or house that you rent

11 - Apartment or house that you own

12 - Staying or living in a family member's room apartment or house

13 - Staying or living in a friend's room apartment or house

14 - Hotel or motel paid for without emergency voucher

15 - Foster care home or foster care group home

16 - Place not meant for habitation

17 - Other

**IV. Destination Tenure:** \_\_\_\_ 1 – Permanent 2 – Transitional 8 - Don't know 9 - Refused

\*(Provide Instructions : "Program Enrollment Housing- Discharged/ Year-Ended -Required")

**V. Destination Subsidy:** \_\_\_\_

0 - None

1 - Public housing

2 - Section 8

3 - S+C

4 - HOME program

5 - HOPWA program

6 - Other housing subsidy

8 - Don't know

9 - Refused

**VI. Reason Discharged:** \_\_\_\_

01 - Left for a housing opportunity before completing program

02 - Completed program

03 - Non-payment of rent or occupancy charge

04 - Non-compliance with project

05 - Criminal activity or destruction of property

06 - Reached maximum time allowed by project

07 - Needs could not be met by project

08 - Disagreement with rules or persons

09 - Death

10 - Unknown or disappeared

11 - Other

\*(Provide Instructions : "Program Enrollment Housing- Discharged/ Year-Ended -Required")

***Performance Measures at Exit (Discharge only)***

**II. Has Housing Plan for establishing or maintaining stable housing been established *at exit from HOPWA*?**  
 *Yes*  *No*

**If yes, date of final stable Housing Plan:** \_\_\_\_\_

**II. Has client had contact with a Case Manager in the last 3 months prior to exit from HOPWA?**  
 *Yes*  *No*

**If yes, Date of Last Made Contact prior to exit:**

**III. Has client had contact with a primary health care provider in the last 3 months (or according to service plan) prior to exit? *Yes*  *No***

**If yes, Date of Last Medical Care Visit?** \_\_\_\_\_

**IV. Does client have Medical Care coverage or medical assistance at exit?  *Yes*  *No***

\*(Provide Instructions : "Program Enrollment Housing –APR Data")

**Provide Instructions:**

- 1. Continuing in HOPWA, enter the Year-End Required data with the status of "Year-Ended".**
  - a. Create a New Program Enrollment Housing (PEH) by saving the "Year-Ended" PEH.**
  - b. Open the new "PEH", verify the Status "Admitted" and the enter required fields to create a PEH document.**
  
- 2. Discharged from HOPWA**
  - a. Enter the status "Discharged" in the PEH.**
  - b. Verify all required fields and are entered before saving the record.**
  - c. After a record is Discharged, it can only be edited by GTI.**
  - d. Discharging prematurely will result in a need to delete and re-enter both Admit and discharge data!!!!**

Contacts At Exit (If changed from entry)

Contact First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Relationship to client:  Attorney  Aunt  Brother  Cousin  Daughter  Friend  Grandparent  Husband  
 Father  Mother  Nephew  Niece  Partner  Sister  Roommate  Wife  
 Step-father  Step-mother  Son  Uncle  Other Relative  Other

OK to contact:  Yes  No

Preferred Method of contact: \_\_\_\_\_

Emergency Contact:  Yes  No

Dependent:

Cohabitant:  Yes  No

Desired Cohabitant:

Household Member:  Yes  No

Next of Kin:  Yes  No

Supportive:  Yes  No

Disabled:  Yes  No

Veteran:  Yes  No

Race: \_\_\_\_\_

Ethnicity:  Hispanic  Non-Hispanic

Date of Birth: \_\_\_\_\_

Monthly Income: \_\_\_\_\_

HIV Status:  Negative  Asymptomatic  
 Symptomatic  AIDS  Unknown

Notified of client's status:  Yes  No

Referred to partner referral program:  Yes  No

Phone Number: \_\_\_\_\_

Message:  Any  None  Name Only  Discreet

Contact Address: \_\_\_\_\_

Contact First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Relationship to client:  Attorney  Aunt  Brother  Cousin  Daughter  Friend  Grandparent  Husband  
 Father  Mother  Nephew  Niece  Partner  Sister  Roommate  Wife  
 Step-father  Step-mother  Son  Uncle  Other Relative  Other

OK to contact:  Yes  No

Preferred Method of contact: \_\_\_\_\_

Emergency Contact:  Yes  No

Dependent:

Cohabitant:  Yes  No

Desired Cohabitant:

Household Member:  Yes  No

Next of Kin:  Yes  No

Supportive:  Yes  No

Disabled:  Yes  No

Veteran:  Yes  No

Race: \_\_\_\_\_

Ethnicity:  Hispanic  Non-Hispanic

Date of Birth: \_\_\_\_\_

Monthly Income: \_\_\_\_\_

HIV Status:  Negative  Asymptomatic  
 Symptomatic  AIDS  Unknown

Notified of client's status:  Yes  No

Referred to partner referral program:  Yes  No

Phone Number: \_\_\_\_\_

Message Type:  Any  None  Name Only  Discreet

Contact Address: \_\_\_\_\_

Contact First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Relationship to client:  Attorney  Aunt  Brother  Cousin  Daughter  Friend  Grandparent  Husband  
 Father  Mother  Nephew  Niece  Partner  Sister  Roommate  Wife  
 Step-father  Step-mother  Son  Uncle  Other Relative  Other

OK to contact:  Yes  No

Preferred Method of contact: \_\_\_\_\_

Emergency Contact:  Yes  No

Dependent:

Cohabitant:  Yes  No

Desired Cohabitant:

Household Member:  Yes  No

Next of Kin:  Yes  No

Supportive:  Yes  No

Disabled:  Yes  No

Veteran:  Yes  No

Race: \_\_\_\_\_

Ethnicity:  Hispanic  Non-Hispanic

Date of Birth: \_\_\_\_\_

Monthly Income: \_\_\_\_\_

HIV Status:  Negative  Asymptomatic  
 Symptomatic  AIDS  Unknown

Notified of client's status:  Yes  No

Referred to partner referral program:  Yes  No

Phone Number: \_\_\_\_\_

Message Type:  Any  None  Name Only  Discreet

Contact Address: \_\_\_\_\_