HOW CAN WE HELP YOU TODAY?
Please fill out and turn in to staff each visit to Uplift U® Dept.

Name: _____ **Date:** _____

Would you move into the shelter **with children?**

Are **already on** the waiting list for Uplift U? Yes (Date :_____) / No / Don't Know

When did you **apply** to the Uplift U® program? (Date: _____) / Never

How can we help you today? **(Circle)**

1. I have no where to stay tonight (emergency shelter)
2. **Homeless School Social Worker** to help my school children with their needs: transportation, uniforms, supplies, case management, etc
3. Apply for Uplift U® Program (I am open to counseling)
4. Outreach services (clothing or food to cook at home)
5. Outreach: Rapid Re-housing (I can pay rent and have money saved but need more affordable rent)
6. Other: _____

Staff only- service transactions-UNITY (PLEASE PUT A CHECK BY WHAT WAS PROVIDED

1. Case management
2. emergency shelter
3. food (lunch or dinner voucher)
4. other_____

Counselor name and title Date

METROPOLITAN MINISTRIES
HOPE IS HERE

PRE-SCREENING QUESTIONS:

What brings you in today? (Check any that apply)

☐ Housing

☐ Emergency Shelter

☐ Overnight Assistance

☐ Uplift U (read brochure first)

Where are you currently staying? Family, Friend, Motel, Other; Please write address:

_____

How long can you stay there? _____

Have you ever lived at Metropolitan Ministries before? ☐ Yes ☐ No

If Yes, when? _____

Do you have children? ☐ Yes ☐ No

How many? Circle 1 2 3 4 5 6 7 8 9 10

Ages? ___, ___, ___, ___, ___, ___, ___, ___, ___, ___

Do you have income? ☐ Yes ☐ No

If yes, how much monthly income? _____

What is the source? _____

Are you being evicted? ☐ Yes ☐ No

Have you ever been evicted? ☐ Yes ☐ No

How many times? _____

Have you ever been arrested? ☐ Yes ☐ No

If yes, what was the charge(s) and when?

Date _____ Charge _____

Date _____ Charge _____

Date _____ Charge _____

Date _____ Charge _____

Have you ever received a mental health diagnosis? ☐ Yes ☐ No

If yes, what was the diagnosis? _____

Who gave you the diagnosis? _____

Have you ever received treatment/medication? ☐ Yes ☐ No

Are you currently on medication? ☐ Yes ☐ No

If yes, what is the name of the medication?

_____

_____

Do you have any chronic health conditions? ☐ Yes ☐ No

If yes, what is the condition?

_____

_____

Do you currently have a pending disability case? ☐ Yes ☐ No

Are you able to work? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

When is your due date: _____ Are you receiving pregnancy care? ☐ Yes ☐ No

Do you use drugs and/or alcohol? ☐ Yes ☐ No

If yes, when was the last time you used drugs/alcohol? _____

Do you have a teenager? ☐ Yes ☐ No

Do they have a juvenile legal background? ☐ Yes ☐ No

Are you looking for temporary housing? ☐ Yes ☐ No

If a family member or friend had housing for you and your children would you go there instead? ☐ Yes ☐ No

Tampa/Hillsborough County CoC
HMIS Universal Intake Assessment

First Name: _____ Middle In: _____ Last: _____ UNITY ID#_____

SSN #: _____ Date of Birth: _____/_____/_____ PROGRAM ENTRY DATE: _____/_____/_____

US Military Veteran? Yes/No/Client Doesn't Know/Client Refused/Data Not Collected

Gender: ___ Male ___ Female ___ Transgender (circle M to F / F to M) ___ Client Doesn't Know ___ Client Refused ___Other ___ Data not collected If other, please specify: _____

If female, answer pregnancy questions below:
Are you pregnant? YES / NO / Client Doesn't Know / Client Refused
If yes, projected date of birth: ___/___/____

Primary Race: ***(may select up to 5)***
___ American Indian/Alaskan Native
___ Native Hawaiian/Pacific Islander
___ Black/African American
___ Asian
___ White
___ Client Refused
___ Client Doesn't Know

Ethnicity:
___ Hispanic/Latino
___ Client Doesn't Know
___ Asian
___ Client Refused

Household Type:
___ Couple with no Children
___ Two Parent Family
___ Female Single Parent
___ Male Single Parent
___ Foster Parent(s)
___ Non-custodial Caregiver(s)
___ Grandparent(s) & Child(ren)
___ Other
___ Minor Parent (Under 18)

Relationship to Head of Household:
___ Self (Head of Household)
___ Head of Household's Child
___ Other: non-relation member
___ Head of Household's
___ Spouse/Partner

Where did you stay last night (Residence Prior to Program Entry)?
___ Emergency Shelter, including hotel or motel paid for with emergency shelter voucher
___ Transitional Housing for Homeless
___ Permanent Housing for Formerly Homeless
___ Psychiatric Hospital or Facility
___ Substance Abuse Treatment Facility or Detox Center
___ Hospital (non-psychiatric)
___ Jail, Prison or Juvenile Facility
___ Rental by client, no subsidy
___ Owned by client, no subsidy
___ Staying or living in a family member's room, apartment or house
___ Staying or living in a friend's room, apartment or House
___ Hotel/Motel without emergency shelter voucher
___ Foster care/group home
___ Place not meant for habitation
___ Safe Haven
___ Rental by client, with VASH subsidy
___ Rental by client, with other (non-VASH) subsidy
___ Owned by client, with housing subsidy
___ Residential Project/Halfway House
___ Long-term care facility/nursing home
___ Rental by client, with GPD TIP subsidy
___ Other
___ Client Doesn't Know
___ Client Refused

Length of Stay
___ One day or less
___ Two days to one week
___ More than 1 week but less than 1 month
___ 1-3 months
___ Client Refused
___ More than 3 months but less than 1 year
___ 1 year or longer
___ Client Doesn't Know

Current Physical Address (NOT a PO Box)
Address (if known): _____
City: _____ **FL Zip**_____
Resident of: ___ City of Tampa ___ Hillsborough County

Contact Information Client Phone Number (___) ___-____ **Client email**: _____
Emergency Contact Name _____ **Contact phone number** (___) ___-____
Location Client Frequents _____**Time of Day Location is Frequented** _____

HOUSING Status:

___ Category 1 - Homeless
___ Category 2 – At imminent risk of losing housing
___ Category 3 – Homeless under other Federal statutes
___ Client Refused
___ Category 4 – Fleeing domestic violence
___ At risk of homelessness
___ Stably Housed
___ Client Doesn't Know

Continuously Homeless for at Least One Year?

___ Yes
___ No
___ Client Doesn't Know
___ Client refused
___ Data not collected

Number of Times Homeless in the Past 3 Years:

___ 0 ___ 1 ___ 2 ___3 ___ 4 or more
___ More than 12 Months
___ Client doesn't know
___ Client refused
___ Data not collected

If 4 or more, Total Number of Months Homeless in the Past 3 Years:

___ Total number of months: _____
___ Client Doesn't Know
___ Client Refused
___ Data not collected

Total number of months continuously homeless immediately prior to project entry: _____

Length of Time Homeless - Status Documented:

___ Yes
___ No

Is client homeless (Federal)? YES / NO

Chronically Homeless Note: Single Individual or Household with at least one member who is: DISABLED, and HOMELESS for 1 year consecutively OR HOMELESS at least 4 times in the past 3 years.

Is client chronically homeless? YES / NO

Client Location (Head of Household): HUD-assigned CoC Code: **FL - 501**

LENGTH OF TIME ON STREET, IN AN EMERGENCY SHELTER, OR SAFE HAVEN (Head of Household and adults)

If client is a US Veteran, complete the following Military questions:

Year Entered Military Service: _____

Year Separated from Military Service: _____

Military Discharge Type :

___ Honorable ___ Bad Conduct
___ Other ___ Dishonorable
___ General ___ Other
___ Client Refused ___ Client Doesn't Know
___ Uncharacterized

Military Branches:

___ US Navy ___ US Coast Guard
___ US Army ___ US Marine Corp
___ US Air Force ___ US National Guard
___ Other ___ Client Refused

Military Service Era –

___ Afghanistan
___ Persian Gulf Era (Aug '91-Sept 10, '01)
___ Iraq Dawn
___ Iraq Freedom
___ Other Peace Keeping or Military Interventions
___ World War II (Sept '40-July '47)
___ Vietnam Era (Aug '64-April '75)
___ Korean War (June '50-Jan '55)
___ Client Doesn't Know
___ Client Refused

Disability of long duration? YES / NO / Client Doesn't Know / Client Refused / Data Not Collected

(Please check each disability that applies and then circle yes or no to both questions)

Disability Type	Is Condition Long Term?	Currently receiving services or treatment?
☐ Both Alcohol and Drug Abuse	Yes/No	Yes/No
☐ Developmental	Yes/No	Yes/No
☐ Physical/Medical	Yes/No	Yes/No
☐ Mental Health Problem	Yes/No	Yes/No
☐ Physical	Yes/No	Yes/No
☐ HIV/AIDS	Yes/No	Yes/No
☐ Physical/Medical	Yes/No	Yes/No
☐ Alcohol Abuse	Yes/No	Yes/No
☐ Chronic Health Condition	Yes/No	Yes/No
☐ Drug Abuse	Yes/No	Yes/No
☐ Dual Diagnosis	Yes/No	Yes/No
☐ Hearing Impaired	Yes/No	Yes/No
☐ Other	Yes/No	Yes/No
☐ Vision Impaired	Yes/No	Yes/No

Receiving any income from any source? YES / NO /Client Doesn't Know /Client Refused / Data Not Collected
If ANY income was received in the past 30 days you must complete the Income Sub-Assessment below:

Source of Income:

$_____ Alimony or Other Spousal Support
$_____ Child Support
$_____ Earned Income
$_____ VA Service Connected Disability
$_____ General Assistance
_____ No Financial Assistance
$_____ Other
$_____ Pension/Retirement (From former job)
$_____ Private Disability Insurance
$_____ Retirement Income from Social Security
$_____ SSDI
$_____ VA Non-Service Connected Disability
$_____ SSI
$_____ TANF
$_____ Unemployment Insurance
$_____ Workers' Compensation

Receiving income source? YES / NO
% of area median income? __ 0% to 30% __31% to 50% __51% to 80% __Over 80% __Don't Know
*if you do not have a copy of the most current Income Limits Summary, check the following web address:
http://www.huduser.org/portal/datasets/il/il2012/2012summary.odn
you will need to select the Metropolitan Fair Market Rent Area from the drop-down.

Non-cash benefit received in past 30 days? YES / NO / Don't Know / Refused
If ANY benefits were received in the past 30 days you must complete the Non-cash Benefits Sub-Assessment below.
Source of Non-cash benefit:

___ Supplemental Nutrition Assistance Program (Food Stamps)
___ Special Supplemental Nutrition Program for WIC
___ Other Source
___ Temporary Rental Assistance
___ TANF Child Care Services
___ TANF Transportation Services
___ Other TANF-Funded Services
___ Section 8, Public Housing, Rental Assistance
___ Other

Receiving benefits? YES / NO

HEALTH INSURANCE
Covered by Health Insurance?
____ Yes ___ Client doesn't know
___ No ___ Client refused

If yes, Answer "yes" or "no" for each health insurance source

___ Yes	___ No	Medicaid	___ Yes	___ No	Employer Provided Health Ins
___ Yes	___ No	Medicare	___ Yes	___ No	COBRA Health Ins
___ Yes	___ No	State Children's Health Ins	___ Yes	___ No	Private Pay Health Ins
___ Yes	___ No	VA Medical Services	___ Yes	___ No	State Health Ins for Adults

Employed? YES / NO / Client Doesn't Know / Client Refused

If yes, type of employment? Part-time / Full-time / Sporadic (including day labor)
If no, why not employed? Looking for work / Unable to work / Not looking for work

Currently in school or working on any degree? YES / NO / Client Doesn't Know / Client Refused

Domestic Violence victim/survivor? YES / NO / Client Refused / Client Doesn't Know
Extent of Domestic Violence?

___ Within the past 3 Months
___ 3-6 months ago
___ From 6-12 months ago
___ 1 year ago or more
___ Client Doesn't Know
___ Client Refused

Which language do you prefer? English/Spanish (circle one)

I certify the information provided above is true and complete to the best of my knowledge. I know I am subject to criminal prosecution if false information is given. I understand the information I provide is protected according to the UNITY Release of Information form and can only be accessed and/or released in accordance with that Agreement.

_____ _____
Completed by staff member **Date of ENGAGEMENT with Client**

_____ _____
Client Signature **Date**

Household Members

PARENT UNITY ID:_____

HOUSEHOLD MEMBER 1 UNITY ID: | **Relationship to you:**

First Name | **MI** | **Last Name**

Zip Code (current or last permanent) **Date of Birth** (mm/dd/yyyy) **Age** **Social Security Number**

Gender
- ☐ Male
- ☐ Female

Ethnicity
- ☐ Hispanic/Latino
- ☐ Non Hispanic/Latino

Race (choose the closest option)
- ☐ American Indian or Alaskan
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White

HOUSEHOLD MEMBER 2 UNITY ID: | **Relationship to you:**

First Name | **MI** | **Last Name**

Zip Code (current or last permanent) **Date of Birth** (mm/dd/yyyy) **Age** **Social Security Number**

Gender
- ☐ Male
- ☐ Female

Ethnicity
- ☐ Hispanic/Latino
- ☐ Non Hispanic/Latino

Race (choose the closest option)
- ☐ American Indian or Alaskan
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White

HOUSEHOLD MEMBER 3 UNITY: | **Relationship to you:**

First Name | **MI** | **Last Name**

Zip Code (current or last permanent) **Date of Birth** (mm/dd/yyyy) **Age** **Social Security Number**

Gender
- ☐ Male
- ☐ Female

Ethnicity
- ☐ Hispanic/Latino
- ☐ Non Hispanic/Latino

Race (choose the closest option)
- ☐ American Indian or Alaskan
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White

HOUSEHOLD MEMBER 4 UNITY ID: | **Relationship to you:**

First Name | **MI** | **Last Name**

Zip Code (current or last permanent) **Date of Birth** (mm/dd/yyyy) **Age** **Social Security Number**

Gender
- ☐ Male
- ☐ Female

Ethnicity
- ☐ Hispanic/Latino
- ☐ Non Hispanic/Latino

Race (choose the closest option)
- ☐ American Indian or Alaskan
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White

HOUSEHOLD MEMBER 5 UNITY ID:		Relationship to you:	

First Name **MI** **Last Name**

Zip Code (current or last permanent) **Date of Birth** (mm/dd/yyyy) **Age** **Social Security Number**

Gender
- ☐ Male
- ☐ Female

Ethnicity
- ☐ Hispanic/Latino
- ☐ Non Hispanic/Latino

Race (choose the closest option)
- ☐ American Indian or Alaskan
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White

HOUSEHOLD MEMBER 6 UNITY ID:		Relationship to you:	

First Name **MI** **Last Name**

Zip Code (current or last permanent) **Date of Birth** (mm/dd/yyyy) **Age** **Social Security Number**

Gender
- ☐ Male
- ☐ Female

Ethnicity
- ☐ Hispanic/Latino
- ☐ Non Hispanic/Latino

Race (choose the closest option)
- ☐ American Indian or Alaskan
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White

HOUSEHOLD MEMBER 7 UNITY ID:		Relationship to you:	

First Name **MI** **Last Name**

Zip Code (current or last permanent) **Date of Birth** (mm/dd/yyyy) **Age** **Social Security Number**

Gender
- ☐ Male
- ☐ Female

Ethnicity
- ☐ Hispanic/Latino
- ☐ Non Hispanic/Latino

Race (choose the closest option)
- ☐ American Indian or Alaskan
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White

HOUSEHOLD MEMBER 8 UNITY ID:		Relationship to you:	

First Name **MI** **Last Name**

Zip Code (current or last permanent) **Date of Birth** (mm/dd/yyyy) **Age** **Social Security Number**

Gender
- ☐ Male
- ☐ Female

Ethnicity
- ☐ Hispanic/Latino
- ☐ Non Hispanic/Latino

Race (choose the closest option)
- ☐ American Indian or Alaskan
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White

Consent and Authorization to Release Information

What is covered in this form?

This form describes how information about you may be used and disclosed, and how you can access this information. Please review it carefully. If you have any questions, please ask the person assisting you.

What is UNITY Information Network?

UNITY Information Network (UNITY) is a computerized record-keeping system. Many social service agencies in Tampa/Hillsborough County, including, Metropolitan Ministries ("Agency"), use UNITY to collect information on clients they serve and the services they provide. The data collected can include name, SSN, date of birth, race, ethnicity, housing status, veteran status, contact information, disability, health insurance status, other personal information, and information about services needed or received.

Why is information about you collected in UNITY?

- To provide and/or coordinate services.
- To assess your needs, the needs of others in our community.
- To reduce duplication of information and decrease the number of wrong referrals you receive.
- To monitor whether your needs and the needs of others in our community were met.
- To decrease the time you spend trying to get services and make sure you get the services you need.
- To improve the quality of care for homeless individuals and families.

How will your information be used and disclosed?

To best serve your needs, social service agencies may need to exchange, share, and/or release information collected about you, and the purpose of this form is to ask your permission to share your information with them as needed.

Signing this form is optional; social service agencies may not refuse to serve you if you do not sign this consent/authorization. However, your consent and authorization is a critical component of our community's ability to provide the most effective services and housing possible.

Your privacy is of ultimate importance, and your data is not shared lightly; the information contained in your UNITY record is considered confidential and privileged and cannot be exchanged, shared and/or released without your express and informed written consent, except where otherwise authorized by law.

Informed written consent occurs through signing this form.

BY SIGNING THIS CONSENT/AUTHORIZATION, I UNDERSTAND:

- UNITY allows information about me to be accessed by, shared with, and updated by any social service agencies using UNITY as needed for service delivery.
- Information about me may be shared and/or discussed to assist me with my housing needs. This means service providers, who may or may not have direct access to UNITY, may review and discuss information about me with each other in a meeting setting. The purpose of sharing this information is to help identify the right program for me based on eligibility and service need. Desired restrictions on data sharing can be submitted in writing to any agency that uses UNITY.
- **Unless I place restrictions in writing on the agencies that may see information about me, all agencies using the UNITY will be able to see the information that this Agency inputs to UNITY**. I understand that upon my request, this Agency must show me a list of the CoC member agencies participating in the UNITY Information Network at the time I sign this consent/authorization. I may also access the most current list at www.THHI.org/unity/.
- Social service agencies that join the UNITY after I sign this consent/authorization also will have access to the personal information I authorize for sharing through this Consent/ authorization. This Agency must make reasonable accommodations for me to view the updated list of CoC member agencies that may access my information pursuant to this consent/authorization for so long as this consent/authorization remains in effect.
- This form authorizes the transfer of my information, including personally identifying information, from UNITY Information Network to a data warehouse environment for coordination of care and data analysis.
- This form authorizes the use of my information in research conducted using information maintained in UNITY. I will not be personally identified by name, social security number, or any other unique characteristic in published research reports.

What rights do you have regarding your information?

You have the right to:

- Inspect and obtain a copy of all your records in UNITY.
- Update information about you when the information in the UNITY record is inaccurate.
- Receive a list of people who have viewed your protected personal data in UNITY for the seven years prior to the date you request the information.
- Revoke your consent/authorization at any time.

You can exercise your rights by making a written request to this Agency.

Your consent/authorization will automatically expire seven (7) years from the date of this form in the event that you do not revoke your consent/ authorization earlier. However, it is important to note that if your consent/ authorization expires or is revoked, the expiration or revocation (as the case may be) shall not apply to any of my data or information that has already been collected.

If you believe that your privacy rights have been violated, you may submit a written complaint to this Agency or submit a written complaint to:

UNITY Information Network
Tampa Hillsborough Homeless Initiative
P.O. Box 1110
Tampa, FL 33601

If you have additional questions that the person assisting you with this form cannot answer, you may contact UNITY Information Network Staff at 813-223-6115.

By signing below, I affirm that I have read this document or it was read and/ or explained to me and I fully understand and agree with the terms of this document.

_____ _____

PRINT CLIENT NAME CLIENT UNITY ID NUMBER

_____ _____

SIGNATURE OF CLIENT OR GUARDIAN DATE

_____ _____ _____

PRINT AGENCY WITNESS SIGNATURE OF AGENCY WITNESS DATE

_____

PRINT AGENCY NAME

Tuberculosis (TB) Symptom Screening Assessment

Client name _____ Date _____
Staff completing _____ Date _____

Have you had any of the following symptoms recently? (circle yes or no)

Cough and/or hoarseness lasting more than 3 weeks?	Yes	No
Recent unexplained weight loss?	Yes	No
Fever or night sweats for more than a week?	Yes	No
A productive cough or coughed up blood?	Yes	No

Do you have Insurance? Yes or No

_____
Staff signature

Unity Number

_____

Limits of Confidentiality:
The purpose of this intake is to assess individual and family needs in order to determine our ability to help you achieve your goals toward self-sufficiency. Certain details may be shared with other intake staff or your family team only as needed to assist with completing your goals if you are selected to enter our program. Although our communications are protected and are confidential, there are a few limits to this confidentiality. These situations include:

- Suspected and/or reported abuse or neglect of any child, elderly person, or vulnerable adult
- Reports of potential harm to self or others
- If we are court ordered for any records of our sessions

We understand that it may be challenging to answer some of the questions on this assessment and want you to know we are committed to supporting you throughout this process. If at any time you need additional support after this assessment is completed, please feel free to reach out to someone on the counseling team. We are all here for you if you find yourself wanting to talk further.
Thank you for being open to sharing part of your story with us!

_____ _____
Client Signature Date

_____ _____
Staff Signature Date