

ESG Assessment Form

Complete one form for each household member

Today's Date: ____/____/____

Staff Member: _____

Name: _____
(First) (Last)

Social Security Number: _____ - _____ - _____ Birth Date: ____/____/____

Disabling Condition: Does any member of the household have a disabling condition?

No Yes Client Doesn't Know Client Refused

If Yes, which household member(s): _____

What type of condition: Physical Developmental Chronic Health Condition
 HIV/AIDS Mental Health Substance Abuse

Currently receiving services for treatment: Yes No

Documentation of the disability and its severity on file: Yes No

Length of Time on Street, in an Emergency Shelter or Safe Haven – Data in this section are used, along with disabling condition, to determine whether or not a client is chronically homeless.

Regardless of where they stayed last night - Number of times the client has been on the streets, in ES, or SH in the past three years including today:

0 (Not homeless, prevention only) 1 (homeless only this time)
 2 3 4 or more
 Client doesn't know Client refused Data Not Collected

Total number of months homeless on the street, in ES, or SH in the past three years (if answer was 0 Above, Not Homeless, do not complete this section):

One Month (this is the first month) 2 3 4 5 6 7 8
 9 10 11 12 More than 12 months
 Client Doesn't Know Client Refused Data Not Collected

Health Insurance Coverage: Yes No Client Doesn't Know Client Refused

If YES, answer "Yes" or "No" for each health insurance source. (Answer no for sources that have been terminated, even if they were receive in the past)

No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Private
<input type="checkbox"/>	<input type="checkbox"/>	Private - Employer
<input type="checkbox"/>	<input type="checkbox"/>	Private - Individual
<input type="checkbox"/>	<input type="checkbox"/>	Medicare
<input type="checkbox"/>	<input type="checkbox"/>	Medicaid
<input type="checkbox"/>	<input type="checkbox"/>	State Children's Health Insurance Program (S-CHIP)
<input type="checkbox"/>	<input type="checkbox"/>	Military Insurance
<input type="checkbox"/>	<input type="checkbox"/>	Other Public
<input type="checkbox"/>	<input type="checkbox"/>	State Funded
<input type="checkbox"/>	<input type="checkbox"/>	Combined Children's Health Insurance/Medicaid Program
<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Services (IHS)
<input type="checkbox"/>	<input type="checkbox"/>	Other

Barriers – Identify whether a client has each individual barrier.

No	Yes	
___	___	Alcohol Abuse
___	___	Developmental Disability
___	___	Domestic Violence
___	___	Drug Abuse
___	___	HIV/AIDS
___	___	Mental Illness
___	___	Physical Disability
___	___	Other: _____

Domestic Violence Assessment – If the client has been a victim of domestic violence, select Yes for Domestic Violence Experience and select when the experience occurred.

Domestic Violence Experienced: ___ Yes ___ No ___ Client Doesn't Know ___ Client Refused

If Yes, when did the experience occur: ___ Within the past three months ___ Three to six months ago
___ Six months to one year ago ___ One year ago or more
___ Client Doesn't Know ___ Client Refused

Currently Fleeing: ___ Yes ___ No ___ Client Doesn't Know ___ Client Refused

Employment:

Currently Employed: ___ Yes ___ No

If Yes, type of employment: ___ Full Time ___ Part Time

If Yes, number of hours worked last week: _____

Employment Tenure: ___ Permanent ___ Temporary ___ Seasonal

If No, why not employed: ___ Looking for work ___ Unable to work ___ Not looking for work

Adult Education

Currently in school/working on degree? ___ Yes ___ No

Received vocational training/Apprenticeship? ___ Yes ___ No

Highest Grade Complete: _____

Secondary Education: _____

Health Assessment

General Health Status: ___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

Pregnancy Status: ___ Yes ___ No If Yes, Due Date: _____

Veteran Status:

Are you a Veteran: ___ Yes ___ No

If Yes, what Branch of Military: ___ Army ___ Air Force ___ Navy ___ Marines
___ Coast Guard ___ Client Doesn't Know ___ Client Refused

Service Entry Date: _____ Service Exit Date: _____

Discharge Status: Honorable General under honorable conditions Bad Conduct
 Under other than honorable conditions (OTH) Dishonorable
 Uncharacterized Client Doesn't Know Client Refused

Theatre(s) of Operations: World War II
 Vietnam War
 Persian Gulf (Operation Desert Storm)
 Afghanistan (Operation Enduring Freedom)
 Iraq (Operation Iraqi Freedom)
 Other Peace-keeping operations of Military Interventions (such as
Lebanon, Panama, Somalia, Bosnia, Kosovo)
 Korean War

Print Full Name

Signature

Date

Staff Member

Date