



HOUSING ASSESSMENT REPORT

This report is 2 pages and MUST be submitted with the Participant Assessment Report. ONLY Sponsoring Agency Staff may complete this report. Every question MUST be answered. This form MUST be completed during the Home Visit. Use additional sheets if necessary.

Please Email or Fax Completed Report By The 5th Day Of The Following Month To:
ccoates@community-partnership.org or Fax# 202.543.5653

Date of visit: _____ Time of visit: _____ am/pm (circle one)

Participant's Name: _____ Sponsoring Agency _____

Address: _____ Unit # _____

Participant's Telephone #: _____

If TCP does NOT administer rental payments for this program, skip to question #6. All others, start from Question #1.

1. Current monthly income: \$ _____ Source _____

2. Has income changed since last month? Y N (Please circle)

If yes, what is new amount? \$ _____ Source: _____

3. If changed, income documentation been submitted to The Community Partnership? Y N (Please circle)
(please note rent cannot be adjusted until documentation is submitted)

4. Has there been a rent increased during this reporting period? Y N (Please circle)
If yes, you must attach a copy of the rent increase letter from the landlord.

5. Has the client paid their portion of the rental obligation? Y N (Please circle)

If NO please indicate Total Amount Owed: \$ _____

6. Are the utilities on and operating properly? Y N Have the utility bills been paid for the month? Y N

7. Please indicate any physical property issues that compromise the Health and Safety of the participant (for example, extermination needs, repair issues, appliance repair issues, DISCONNECTED utilities etc):

8. Is apartment/housing in need of maintenance repairs? Y N (Please circle)

If yes, please list all maintenance requests: (provide specific information, use a separate sheet if necessary).

1. _____

2. _____

9. Was the landlord notified of repairs needed? Y N (Please circle)

If Yes, when? _____ Date of case management follow-up: _____

10. Are all smoke detectors in unit/housing operable? Y N (Please circle) # tested: _____

NOTE: AN ANSWER OF "NO" IS UNACCEPTABLE AND MUST BE REPORTED IMMEDIATELY.

Signature of Sponsoring Agency Staff Completing Report

Date

Participant's Signature

Date



PARTICIPANT ASSESSMENT REPORT

(This report is 2 pages and MUST be submitted with the Housing Assessment Report. ONLY Sponsoring Agency Staff may complete this report. Every question MUST be answered. This form MUST be completed during the Home Visit. Use additional sheets if necessary.)

Participant's Name: _____ Sponsoring Agency _____

Unit Configuration: Individual Family Shared (please circle one)

1. Please briefly describe the clients' physical appearance and mental state(s). _____

2. Has the family configuration changed? Y N (Please circle one. If yes, please complete the table below and indicate the change.)

3. For families, were minor children present during the Home Visit? _____

For Family and Shared Units ONLY, Please list the names AND ages of all persons OTHER than the client residing in the Unit. Please indicate which family/household members were present during the visit.

Name	Relationship	SEX	Age	Present? Y or N	Disability (if any)

4. What service(s) has the participant used during this reporting period? Please check all that apply.

- Food Bank
 Legal
 Job Training/Education
 Substance Abuse
 Mental Health
 Emergency Financial Assistance
 HIV/AIDS
 Other Medical
 Child care
 Transportation
 Miscellaneous

5. When was the client's last Doctor's or Therapist Visit? _____ (please enter specific date)

6. If applicable, is the client medication compliant? Y N (Please circle)

(If no, please address in Q. #8.)

7. Does the client have a current Individual Case Plan? Y N (Please circle)

(If no, please address in Q. # 8.)

8. Please briefly describe what case management support has been offered to assist client with completing the goals outlined in the case plan. _____

9. Has the client reported any barriers to accessing services offered? Y N (Please circle one)

For service delivery, is the client ENGAGED or RESISTANT? (Please check one)

10. Please briefly describe your overall interaction with the client during this appointment. (Use additional sheets if necessary)

11. Date of next scheduled home visit: _____