



Butte County COVID-19 Assessment

Assessment Date: _____

Client Information:

Client Name: _____ Client DOB: _____
Phone Number: _____ Email Address: _____
Gender: _____

HMIS Enrollment Information:

SSN: XXX-XX-_____ Race: _____ Ethnicity: Hispanic Non-Hispanic
Prior living situation? _____ Type of last residence? _____
Length of stay in prior living situation? _____
Approx. date homelessness started? _____
No. of times on street, Emergency Shelter (ES) or Safe Haven (SH) in past 3 years? _____
Total # of months homeless on street in ES or SH in past 3 years? _____
Disabling Condition: Yes No Access/Functional Needs Identified: Yes No
Pets in the household? _____ Service animal in household? _____

General Health Assessment. Check Yes or No.

Current Temperature: _____
Do you have a cough? Yes No
Are you feeling feverish? Yes No
Do you have difficulty breathing (worse than usual)? Yes No
Have you been exposed to COVID-19? Yes No
Did you test positive for COVID-19? Yes No

Do you have any of the following health conditions?

Please select all that apply.

Chronic lung disease or moderate to severe asthma Yes No
Serious Heart Condition Yes No
Immunocompromised (including cancer treatment) Yes No
Diabetes Yes No
Chronic Kidney disease undergoing dialysis Yes No
Liver Disease Yes No
High Blood Pressure Yes No

Information Collected By:

Agency: _____

Agency Staff: _____ (Signature) _____ (Print Name) Date: _____

Please scan and email completed form to: HHSupport@buttecounty.net

Email questions to: HHSupport@buttecounty.net