

Effective 10/1/2021

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HMIS Intake Form for PSH projects

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Housing Move-in Date

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Health Insurance

- ☐ No ☐ Client doesn't know
☐ Yes (identify source below) ☐ Client

Source:

- | | |
|--|--|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Medicare |
| <input type="checkbox"/> State Children's Health Insurance (KCHIP) | <input type="checkbox"/> VA Medical Services |
| <input type="checkbox"/> Employer-Provided Health Insurance | <input type="checkbox"/> Health Insurance obtained through COBRA |
| <input type="checkbox"/> Private Pay Health Insurance | <input type="checkbox"/> State Health Insurance for Adults |
| <input type="checkbox"/> Indian Health Services Program | <input type="checkbox"/> Other: _____ |

Disability

Do you have a physical, mental or emotional impairment, a post-traumatic stress disorder, or brain injury; a development disability, HIV/AIDS, or a diagnosable substance abuse problem?

- ☐ No ☐ Yes (indicate type(s) below) ☐ Client doesn't know ☐ Client refused

	Physical <input type="checkbox"/>	Mental Health <input type="checkbox"/>	Chronic Health Condition <input type="checkbox"/>	<input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Both	Developmental <input type="checkbox"/>	HIV/AIDS <input type="checkbox"/>
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

****Only answer the following questions for Adults and HoH. ****

Income

- ☐ No/None at all ☐ Yes (identify source and amounts)
☐ Client doesn't know ☐ Client refused

Source:

Amount:

- | | |
|---|--------------|
| <input type="checkbox"/> Earned income (i.e., employment income) | \$_____ . 00 |
| <input type="checkbox"/> Unemployment Insurance | \$_____ . 00 |
| <input type="checkbox"/> Supplemental Security Income (SSI) | \$_____ . 00 |
| <input type="checkbox"/> Social Security Disability Income (SSDI) | \$_____ . 00 |
| <input type="checkbox"/> Retirement Income from Social Security | \$_____ . 00 |
| <input type="checkbox"/> VA Service-Connected Disability Compensation | \$_____ . 00 |
| <input type="checkbox"/> VA Non-Service-Connected Disability Pension | \$_____ . 00 |
| <input type="checkbox"/> Worker's Compensation | \$_____ . 00 |
| <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) | \$_____ . 00 |
| <input type="checkbox"/> General Assistance (GA) | \$_____ . 00 |
| <input type="checkbox"/> Private disability Insurance | \$_____ . 00 |
| <input type="checkbox"/> Pension or retirement income from a former job | \$_____ . 00 |
| <input type="checkbox"/> Child Support | \$_____ . 00 |
| <input type="checkbox"/> Alimony or other spousal support | \$_____ . 00 |
| <input type="checkbox"/> Other source: _____ | \$_____ . 00 |

Total Monthly Income:

\$

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Non-Cash Benefits	
<input type="checkbox"/> No/None at all	<input type="checkbox"/> Yes (Identify source below)
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
Source:	
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) <input type="checkbox"/> Special Supplemental, Nutrition Program for Women, Infants, and Children (WIC) <input type="checkbox"/> TANF Child Care services <input type="checkbox"/> TANF transportation services <input type="checkbox"/> Other TANF-funded services <input type="checkbox"/> Other: _____	

Client's Prior Living Situation - Prior to Project Entry			
(Select one Living Situation and answer the corresponding questions in the order in which they appear)			
Literally Homeless Situation	Institutional Situation	Transitional/Permanent Housing Situation	Other
<input type="checkbox"/> Place not meant for habitation (e.g. a vehicle, abandoned building, bus/train/subway station, airport, anywhere outside). <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher <input type="checkbox"/> Safe Haven	<input type="checkbox"/> Foster care home or foster group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host Home (non-crisis) Staying or living in a friend's room, apartment or house <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Rental by client, with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client with other ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
Length of Stay in Prior Living Situation (i.e. the literally homeless situation identified above)? <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more but less than one month <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> 90 days or more but less than one year <input type="checkbox"/> One year or longer	Length of Stay in Prior Living Situation (i.e. the institutional situation identified above)? <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more but less than one month <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> 90 days or more but less than one year <input type="checkbox"/> One year or longer Did you stay in the institutional situation less than 90 days? <input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO – End Homeless History Interview)	Length of Stay in Prior Living Situation (i.e. the housing situation identified above) <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more but less than one month <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> 90 days or more but less than one year <input type="checkbox"/> One year or longer Did you stay in the housing situation less than 7 nights? <input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO – End Homeless History Interview)	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused

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<input type="checkbox"/> N/A (Complete SECTION IV Below)	On the <u>night before</u> entering the institutional situation did you stay on the streets, in emergency shelter or a safe haven? <input type="checkbox"/> Yes (If YES – Complete SECTION IV) <input type="checkbox"/> No (If NO – End Homeless History Interview)	On the <u>night before</u> entering the housing situation did you stay on the streets, in emergency shelter or a safe haven? <input type="checkbox"/> Yes (If YES – Complete SECTION IV) <input type="checkbox"/> No (If NO – End Homeless History Interview)	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
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On the night <u>before your previous stay</u>, was that on the streets, in an Emergency Shelter, or Safe Haven? <input type="checkbox"/> No <input type="checkbox"/> Yes	Approximate start of homelessness: <table border="1"><tr><td></td><td></td><td></td><td>/</td><td></td><td></td><td></td><td>/</td><td></td><td></td></tr></table>				/				/		
			/				/				
Total <u>number of times homeless</u> on the street, in ES, or SH in the past three years <input type="checkbox"/> One time <input type="checkbox"/> Two times <input type="checkbox"/> Three times <input type="checkbox"/> Four times <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	Total <u>number of months</u> homeless on the street, in emergency shelter, or SH in the past three years _____										

Domestic Violence							
Are you, or have you been a survivor of domestic or intimate partner violence? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused							
If YES, how long ago did you have this experience? <table><tr><td><input type="checkbox"/> Within the past 3 months</td><td><input type="checkbox"/> 1 year ago or more</td></tr><tr><td><input type="checkbox"/> 3 to 6 months ago</td><td><input type="checkbox"/> 6 months to 1 year ago</td></tr><tr><td><input type="checkbox"/> Client doesn't know</td><td><input type="checkbox"/> Client refused</td></tr></table>		<input type="checkbox"/> Within the past 3 months	<input type="checkbox"/> 1 year ago or more	<input type="checkbox"/> 3 to 6 months ago	<input type="checkbox"/> 6 months to 1 year ago	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
<input type="checkbox"/> Within the past 3 months	<input type="checkbox"/> 1 year ago or more						
<input type="checkbox"/> 3 to 6 months ago	<input type="checkbox"/> 6 months to 1 year ago						
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused						
If Yes, are you currently fleeing? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused							

Foster Care <input type="checkbox"/> Yes <input type="checkbox"/> No	Zip Code of Last Permanent Address <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>						

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Client perceives their life has value and worth.	
<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Strongly agree
<input type="checkbox"/> Somewhat disagree	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Neither agree nor disagree	<input type="checkbox"/> Client refused
<input type="checkbox"/> Somewhat agree	
Client perceives they have support from others who will listen to problems.	
<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Strongly agree
<input type="checkbox"/> Somewhat disagree	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Neither agree nor disagree	<input type="checkbox"/> Client refused
<input type="checkbox"/> Somewhat agree	
Client perceives they have a tendency to bounce back after hard times.	
<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Strongly agree
<input type="checkbox"/> Somewhat disagree	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Neither agree nor disagree	<input type="checkbox"/> Client refused
<input type="checkbox"/> Somewhat agree	
Client's frequency of feeling nervous, tense, worried, frustrated, or afraid.	
<input type="checkbox"/> Not at all	<input type="checkbox"/> At least every da
<input type="checkbox"/> Once a month	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Several times a month	<input type="checkbox"/> Client refused
<input type="checkbox"/> Several times a week	
General Health Status	
<input type="checkbox"/> Excellent	<input type="checkbox"/> Poor
<input type="checkbox"/> Very Good	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Good	<input type="checkbox"/> Client refused
<input type="checkbox"/> Fair	

Staff Completing (Printed Name):

Date:

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