

Effective 10/1/2023

(HoH) ID:

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☐ Client Refused☐ Client refused☐ Client refused

<input type="checkbox"/> American Indian, Alaska Native, or Indigenous	<input type="checkbox"/> Native Hawaiian or Pacific Islander
<input type="checkbox"/> Asian or Asian American	<input type="checkbox"/> White
<input type="checkbox"/> Black, African American, or African	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Hispanic/Latina/e/o	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Middle Eastern or North African	
<input type="checkbox"/> Additional Race and Ethnicity detail: _____	

<input type="checkbox"/> Woman (Girl, if child)	<input type="checkbox"/> Questioning
<input type="checkbox"/> Man (Boy, if child)	<input type="checkbox"/> Different Identity
<input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit)	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Transgender	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Non-Binary	
<input type="checkbox"/> If Different Identity, Please Specify _____	

☐ Other: non-relation member

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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 (do not answer for minors unless they are the 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)				
Homeless Situations	Institutional Situations	Temporary Housing Situations	Permanent Housing Situation	Other
<input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home shelter <input type="checkbox"/> Safe Haven	<input type="checkbox"/> Foster care home or foster care 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"/> Transitional housing for homeless persons (including homeless youth) <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"/> Host Home (non-crisis) <input type="checkbox"/> 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, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with ongoing housing subsidy <ul style="list-style-type: none"> <input type="checkbox"/> GPD TIP housing subsidy <input type="checkbox"/> VASH housing subsidy <input type="checkbox"/> RRH or equivalent subsidy <input type="checkbox"/> HCV voucher (tenant or project based) (not dedicated) <input type="checkbox"/> Public housing unit <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Emergency Housing Voucher <input type="checkbox"/> Family Unification Program Voucher (FUP) <input type="checkbox"/> Foster Youth to Independence Initiative (FYI) <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Other permanent housing dedicated for formerly homeless persons <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy	<input type="checkbox"/> Other <input type="checkbox"/> Worker unable to determine <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
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)	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 prefers not to answer

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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)	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 prefers not to answer
	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 date this episode of homelessness started: <div style="border: 1px solid black; width: 150px; height: 20px; margin: 0 auto;"></div>	
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 prefers not to answer			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? <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 3 to 6 months ago <input type="checkbox"/> Client doesn't know </div> <div> <input type="checkbox"/> 1 year ago or more <input type="checkbox"/> 6 months to 1 year ago <input type="checkbox"/> Client refused </div> </div>	
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	Zip Code of Last Permanent Address
<input type="checkbox"/> Yes <input type="checkbox"/> No	<div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>

PSH Projects ONLY (RRH is Exempt) Sexual Orientation	
<input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> If Other, Please Describe: _____	<input type="checkbox"/> Other <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

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Translation Assistance Needed	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (identify preferred language(s))
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
Preferred Language(s)	<div><input type="checkbox"/> Amharic <input type="checkbox"/> Arabic <input type="checkbox"/> Bosnian <input type="checkbox"/> Burmese <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Croatian <input type="checkbox"/> Dari <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Gujarati <input type="checkbox"/> Haitian Creole <input type="checkbox"/> Hawaiian <input type="checkbox"/> Hindi <input type="checkbox"/> Ilocano <input type="checkbox"/> Japanese <input type="checkbox"/> Karen <input type="checkbox"/> Kinyarwand <input type="checkbox"/> Korean <input type="checkbox"/> Lingala <input type="checkbox"/> Luganda <input type="checkbox"/> Mandarin <input type="checkbox"/> Marathi <input type="checkbox"/> Nepali <input type="checkbox"/> Pashto <input type="checkbox"/> Portuguese <input type="checkbox"/> Russian <input type="checkbox"/> Samoan <input type="checkbox"/> Serbian <input type="checkbox"/> Somali <input type="checkbox"/> Spanish <input type="checkbox"/> Swahili <input type="checkbox"/> Tamil <input type="checkbox"/> Telugu <input type="checkbox"/> Ukrainian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Wolof <input type="checkbox"/> Yiddish <input type="checkbox"/> Different Preferred Language <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Prefers Not to Answer <input type="checkbox"/> Data Not Collected</div>
	If Different Preferred Language, please specify

Staff Completing (Printed Name):

Date:

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